Enhancement of an Integrated Model of Prenatal Assessment and Care on P.E.I.

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Enhancement of an Integrated Model of Prenatal Assessment and Care on Prince Edward Island

FINAL REPORT

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Table of Contents

Page

Executive Summary 1

Purpose/Objectives 4

Project Activities 4

Project Results 8

Dissemination Plan 38

Appendices

Appendix A: Prenatal Psychosocial Assessment Tools
Appendix B: Prenatal Psychosocial Assessment Model & Guidelines
Appendix C: Evaluation Plan
Appendix D: Evaluation Tools
Appendix E: Data Summary: Physician Pre-Education Survey
Appendix F: Data Summary: Physician Telephone Interview
Appendix G: Data Summary: Referral Network Mail Survey
Appendix H: Data Summary: Advisory Committee Focus Group Discussion
Appendix I: Eight Dissemination Methods for ALPHA Pilot
Appendix J: Guidelines for Education of Physicians
Appendix K: Education Resource Package
Appendix L: Media Coverage

Executive Summary

Purpose: The purpose of this initiative is to enhance the psychosocial component of prenatal assessment and care for all pregnant women across PEI, while at the same time broadening the range of health providers and supports in a more integrated, collaborative, and responsive system. Psychosocial risks during pregnancy can have a major impact on the health of the mother, newborn, and family. This initiative promotes assessment and intervention during pregnancy in an attempt to reduce risks and enhance health outcomes.

Target Audience: Pregnant women on PEI are being assessed at approximately 20 weeks gestation by their family physician for a number of psychosocial risks including: stress; lack of social support; woman abuse; experience of child abuse; smoking, alcohol, and drug abuse; parenting/discipline issues; lack of finances; psychiatric disturbances; couple relationship issues, etc. When a family physician has not agreed to complete the assessment, the woman's obstetrician has the option of completing it or sending the woman to Public Health Nursing to have the assessment done. Referrals are made to appropriate community based services using a referral form designed specifically for the assessment. Referral agencies have agreed to respond to referrals from physicians and will communicate in writing to physicians regarding the outcome of the referral.

Activities: From October 1998 through February 1999, activities centred around completion of the ALPHA Pilot Study, which served as the underpinnings of the current initiative. In late February 1999, the Project Advisory Committee was formed and met for the first time. An attempt was made to draw a diverse group of committed individuals together to guide the Project. One of the very first decisions made by the Advisory Committee was that family physicians be approached to take on the enhanced assessment. It is important to note that a high percentage of these physicians do not routinely provide prenatal care. The issue of physician remuneration was addressed with a very positive outcome. A request was made to and approved by the Department of Health and Social Services and the Medical Society that physicians receive remuneration for completing the assessment. This was a major achievement.

Both of the assessment tools used in the pilot study were adapted with permission from the original authors, the ALPHA Team. The adapted assessment tools were also translated into French, to accommodate French speaking women on PEI. The ALPHA Reference Guide was adapted to coincide with the adapted tools. A Prenatal Resource Directory was developed to assist physicians in making referrals following assessments.

Referral networks were identified in each health region, and meetings were held with managers from each identified referral agency. The Project, the pilot results, and the process of referrals were discussed. A form was developed that serves as a referral/ communication tool for the assessment and follow up, as well as a tracking system to assist in evaluating the Project.

A 1.5 hour session was developed to educate physicians regarding the assessment. A video was developed as a teaching tool, and it proved to be invaluable during the education sessions, along with the other previously mentioned resources. In total, 56 education sessions were held from November 1999 through August 2000; 15 group physician sessions, 32 individual physician sessions, and 9 Public Health Nursing (PHN) sessions. Seventy-eight of the 80 Island family physicians and obstetricians attended the education sessions. Of the 78 physicians who attended, 73 agreed to do or assist with the assessment. The enhanced assessment began in two health regions in March, two in June, and the final region in August 2000.

Main Findings: The main sources of evaluation data for the PPA Project were from physicians, Public Health nurses, referral network personnel, Project records, Project staff, and Project Advisory Committee members. After a 1-3 month implementation period, those trained to conduct the enhanced Prenatal Psychosocial Assessment (PPA) were surveyed using a telephone interview. Ninety-seven percent (36/37) of respondents were well satisfied with the education sessions and 92% (34/37) thought that the education resources met their needs. Forty-six percent (17/37) had completed one or more assessments, 76% (28/37) planned to complete the PPA with their clients, while the remaining 24% (9/37) had not performed the PPA for a variety of reasons.

Measurement of four indicators of physician preparedness (knowledge, commitment, comfort, and support) before the education session and after the 1-3 month implementation period indicated that for all four indicators, the percentage of positive responses increased: knowledge (43% vs. 84%); commitment (54% vs. 73%); comfort, (54% vs. 78%); and support (85% vs. 89%).

Little change was observed in the number of referrals and the ease of access to clients, primarily due to the limited time frame between implementation and evaluation. There was evidence that physician awareness of services and communication between doctor and patient had improved as a result of implementation of the PPA. Among the 17 doctors having already completed a PPA, 10 reported that no woman refused a referral and 5 reported that women had refused a referral, often for a valid reason.

The types of interventions resulting from use of the PPA included counselling (breast-feeding, nutrition, mental health, lifestyle, psychiatric, relationships, and stress) and smoking cessation. The detection of psychosocial issues was very evident in the reasons given for referrals. Although the period of study was limited and hence the

sample size was small, the prediction from various sources of data was that early detection and intervention would be beneficial to all concerned whether a mother, infant, family, community, or the health care system.

Introducing the PPA into practice was a positive experience. Issues to be addressed include: 1) time to complete the assessment; 2) remembering to schedule the assessment; 3) adequate provider compensation for services rendered; and 4) elimination of procedural glitches associated with the start of a new province-wide program.

Among respondents to the post-implementation Physician Telephone Interview, 29/37 believed that their clients were satisfied with the PPA. Twenty-three of 35 physicians were satisfied with the referral portion of the PPA, with no physician being dissatisfied. Should the assessment be continued? Yes, according to 84% (31/37) of the respondents, and both (2/2) of the referral network respondents, who had received referrals as a result of the PPA being implemented. Considering all data collected for the Project, the PPA can do much to improve health and life in general for PEI prenatal clients, as the province-wide model becomes more fully understood and practised with the target population.

Recommendations/Policy Implications: This project is not likely to create specific policy changes but rather it has endeavoured to change a standard of prenatal care. The initiative has had an impact on physician practice and will facilitate behaviour change among physicians through increasing knowledge, developing skills, and changing attitudes. This is much bigger than changing any one policy and will promote sustainability. The primary users of the enhanced Prenatal Psychosocial Assessment Model to date are family physicians. Overall, the high level of support for the enhanced version of prenatal assessment and care almost guarantees its long-term use.

The PEI Reproductive Care Program Joint Planning Committee is committed to examining issues identified by this early evaluation of the PPA implementation and to finding suitable solutions to any start-up problems. In short, the Program will take responsibility for fine-tuning the PPA procedures so that the PPA Model becomes a sustainable model that is available to all prenatal clients.

Project Objectives

The main objectives of the "Enhancement of an Integrated Model of Prenatal Assessment and Care on Prince Edward Island Project" were:

1. To improve prenatal assessment and care across the Province by having psychosocial assessment enhanced as a standard part of prenatal care;

2. To improve the integration of the prenatal service delivery system;

3. To improve the health of Island mothers and infants by reducing psychosocial risks and improving outcomes; and

4. To reduce resource demands on the health system and promote resource reallocation.

Project Activities

The following is an overview of the activities of the Project that have been completed as per the work plan.

Completion of ALPHA Pilot & Dissemination of Results: From October 1998 through February 1999, activities centred around completion of the ALPHA Pilot Study, which served as the underpinnings of the current project. Final interviews were completed in October, and then qualitative and quantitative data analyses were done. The final report was completed in February, and 250 copies were disseminated within PEI and across Canada. Copies were disseminated across PEI to: family physicians, obstetricians, pediatricians, Public Health nurses, nutritionists, Child Welfare supervisors, Community Mental Health managers, Addiction Services, Outreach Workers, and Victim Services. The Project Advisory Committee and the Premier's Action Committee on Family Violence Prevention also received copies.

The report was also sent to provincial Family Violence Coordinators across Canada, Canadian Perinatal Programs Coalition members, and the ALPHA Team from the University of Toronto. In addition to dissemination of the report, a verbal presentation of the results was developed. Seventy presentations have been made across PEI to date to a number of groups including: staff in the five health regions, the Premier's Action Committee on Family Violence Prevention, the provincial and hospital perinatal committees, Public Health Nursing, and referral network personnel. Forty-seven of these presentations were part of the education sessions provided to physicians. A presentation was made at the Atlantic Centre for Health Promotion Research Conference, and a poster presentation was also created and presented at The Medical

Society of PEI's annual meeting. An abstract describing the pilot results and Project activities has been accepted for presentation at the North American Primary Care Research Conference in November 2000. As well, articles have been submitted for publication to the Canadian Family Physician Journal and the Canadian Journal of Nursing Research.

Advisory Committee Formation: In late February 1999, the Project Advisory Committee was formed and met for the first time. An attempt was made to draw a diverse group of committed individuals together to advise the Project. Membership included four physicians, three nurses, a family violence consultant, an addictions consultant, and a consumer. There was an excellent mix of front line service providers and policy makers. This was a very dynamic group of people who were very supportive of the initiative and who had tremendous insight into how to make the Project work. The Advisory Committee reported to the PEI Reproductive Care Program Joint Planning Committee through the co-chairs. This committee met eleven times to guide the work of the Project.

Provider Selection/Negotiation: One of the very first decisions made by the Advisory Committee in February 1999 was that physicians be approached to take on the enhanced assessment. The physicians on the Committee were very supportive and believed that the assessment should be part of the physician's role. It was decided that family physicians should be the group primarily responsible for the assessment but that it would also be left open for obstetricians to do the assessment if a family physician chose not to complete it. It must be noted that on PEI, a high percentage of family physicians do not routinely provide prenatal care. Following this decision, the issue of physician remuneration was addressed with a very positive outcome. A request was made to and approved by the Department of Health and Social Services and the Medical Society that physicians receive remuneration for the assessment. This was a major achievement and was completed in a much shorter time frame than the year projected in the work plan. Although the remuneration was a critical piece, it also has two problems associated with it. The fee is less than a regular office visit and physicians who routinely do prenatal care cannot bill for this assessment along with a regular prenatal visit. Both of these issues will be addressed in the next round of negotiations regarding the Master Agreement between the Medical Society and the Department of Health and Social Services. As well, the PEI Chapter of the College of Family Physicians and The Medical Society of PEI endorsed the initiative. This support from the medical community facilitated the work of the Project.

Tool Adaptation and Process for Use: Both of the assessment tools used in the pilot study were adapted with permission from the original authors, the ALPHA Team. The adaptation of the tools was based on the results of the pilot study and reflected the opinions of the physicians, Public Health nurses, and the women involved in the pilot. This adaptation also fell within the expected time frame. The adapted tools were

translated into French to meet the needs of Francophone women. Copies of the adapted tools are located in Appendix A. A decision was made to use both adapted tools. The woman completes the **Ask Me! Identifying Stressors for Pregnant Women** form and then the physician uses the **Prenatal Psychosocial Health Assessment** form to guide him/her in exploring areas of concern and in documenting the findings of the assessment. The ALPHA Reference Guide was also adapted to coincide with the adapted tools. The **Prenatal Psychosocial Health Assessment Reference Guide** (adapted version) was used to facilitate physician education and was a very helpful resource in assisting physicians with the assessment, follow up care, and referral. A **Prenatal Resource Directory** was also developed to assist physicians in making referrals following assessments. This was distributed and discussed at the physician education sessions. These two resources were not part of the original proposal but were produced to facilitate the work of the Project.

Referral Networks: As planned, referral networks were identified in each region, and meetings were held with managers from each identified referral agency. The Project, the pilot results, and the process of referrals were discussed. The attendance at the meetings was very good and the support received was tremendous. The referral personnel were very excited about the initiative and provided very good suggestions regarding the referral process, as well as the Referral/Communication form. Unfortunately because it took longer than expected to implement the physician education sessions and initiate the assessment, there is little feedback from the referral networks for the evaluation component.

Referral/Communication Form: A form was developed that serves as a referral/ communication tool for the assessment and follow up as well as a tracking system to assist in evaluating the Project.

Physician Education: A 1.5 hour session was developed to educate physicians regarding the assessment. The education session was approved for Continuing Medical Education credits through the College of Family Physicians, as this was believed to be an incentive for physician attendance. It proved to be an incentive for some but not the majority of physicians. A video was developed as a teaching tool, and it proved to be invaluable during the education sessions, along with the other resources previously mentioned. A family physician, who participated in the pilot, role-played an assessment with an actress playing the role of a pregnant woman. This video was not part of the original proposal but was suggested by the Advisory Committee as an effective way to educate physicians.

In total, 56 education sessions were provided. Originally group sessions were planned, which started in November 1999. It became obvious that it would not be possible to reach all family physicians and obstetricians across PEI in this manner, so a shorter individual session was also developed. To reach physicians required a great deal of

flexibility, persistence, numerous phone calls, and scheduling/rescheduling appointments. It became clear that "one size does not fit all" to meet the educational needs of physicians. As well, adapting to a change in practice does not occur at the same rate by all. A total of 15 group sessions and 32 individual sessions were conducted with physicians. This meant travelling across PEI and meeting physicians at times and places convenient to them. In total, 78 of the 80 Island family physicians and obstetricians have been educated in the new assessment. This took place between November 1999 and August 2000, which is considerably longer than the projected time. The two physicians who have not been reached have not provided a time for the Coordinator to do the session, even though numerous contacts have been made with their office. Of the 78 physicians who have been educated in the assessment, five have chosen not to do the assessment. In these cases the obstetrician has the option of doing the assessment or sending the woman to Public Health Nursing to have the assessment done. Nine group education sessions were held with Public Health nurses across the province. Physicians' office staff were also given a brief overview of the assessment and their roles regarding scheduling appointments for women to return for the assessment. The Prenatal Psychosocial Assessment Model and guidelines for the assessment and referral process are located in Appendix B.

The education sessions were by far the major component of the Project, requiring the most time and resources. Twelve group sessions over 5 weeks were anticipated and in reality 56 group and individual sessions were carried out over 10 months. Some of the facilitators related to this component included the pilot study results, the educational resources developed, the flexibility allowed, the small size of the province for travel, approval of billing, endorsement by the College of Family Physicians and Medical Society, physician champions, and the effort made to make a personal contact with each physician. The barriers that had to be overcome included physician lack of time, the amount of the remuneration, winter travel, office gatekeepers, physician shortage/resource issues, the flu season, etc.

Implementation of the Assessment: Two regions of the province began the assessment in March 2000, two more in June, and the final region in August. As mentioned previously, of the 78 physicians who have been educated in the assessment, only five have chosen not to do the assessment. Their reasons included lack of time and not being able to receive remuneration to do the assessment with a regular prenatal visit. These results far surpass what was originally deemed possible. Persistence and personal face-to-face contact were essential. As with any major change in practice/behaviour, there continue to be a few kinks to be ironed out. Remembering to book the appointments for women to have the assessment completed continues to be a problem. Reminder signs have been developed and given to offices where this is an issue. As well, because it took longer than anticipated to reach all physicians with the education session, the implementation of the assessment was delayed by 6 months. Because it began such a short time before the evaluation was

required, it was not possible to determine the full impact of the assessment and referral process.

Evaluation: The Public Health and Evaluation Division of the Department of Health and Social Services of Prince Edward Island provided evaluation support services to the Project through a Health System Research Consultant and Research Assistant. These staff collaborated with the Project staff, Project Advisory Committee, and the Evaluation Sub-committee (the latter being struck from the larger Advisory Committee membership and included the Evaluation Consultant, Research Assistant, Project Coordinator, Family Violence Consultant, and Addictions Consultant). This sub-committee met nine times.

Project Results

Introduction: An evaluation framework was developed for the Prenatal Psychosocial Assessment Project by the Evaluation Sub-Committee and Evaluation Services. It is shown in Appendix C. Five primary questions and 26 supporting secondary questions were used to assess the Project.

Sample: There are 80 physicians (73 family doctors and 7 obstetricians), Public Health nurses in five regions, and numerous referral network providers on PEI. Among them 78 physicians, most PHNs, and 31 referral agency managers attended education/information sessions regarding the assessment. Among the education session attendees, 46 physicians completed the Physician Pre-Education Survey. Thirty-five doctors and 2 Public Health nurses responded to the post-implementation Physician Telephone Interview (n=37), while 9 referral network providers, e.g., Public Health nurses, social workers, psychologists returned the Referral Network Mail Survey. The response rates were 59% and 55%, respectively. Data were also collected from Project Advisory Committee members, Project staff, and Project documents. The data sources used to evaluate the PPA implementation are shown in Table 1, and the evaluation tools are presented in Appendix D.

Evaluation Questions: The areas of inquiry were consistent with the evaluation guidelines provided by the Health Transition Fund and were designed to: 1) capture the results; 2) address implementation and delivery issues; and 3) address the four evaluation categories specified, namely, quality of service, health impacts/effects, cost-effectiveness, and transferability/generalizability. The five primary evaluation questions are shown on page 9.

Table 1. Summary of Project Data Sources				
#	Tool Name	Method	Sampling Frame	n
1	Physician Pre-Education Survey	Pen-and-Pencil Survey	Physicians attending group education sessions	46
2	Physician Telephone Interview (Post-Implementation)	Telephone Interview	Physicians/PHNs (35/2) who received education session and willingly responded	37
3	Referral Network Mail Survey	Mail Survey	Managers of the various referral networks agencies	9
4	Project Staff Implementation Interview	Semi-structured Interview	Project Coordinator, Family Violence Consultant	2
5	Project Staff Implementation Logs	Logs & Minutes	Project Coordinator	1
6	Advisory Committee Focus Group	Focus Group	Members of Committee	10

Primary Evaluation Questions

1. To what degree has the project enhanced prenatal psychosocial assessment for all expectant mothers on PEI?
2. To what degree has the project led to an appropriate and integrated response to identified psychosocial needs or risk factors?
3. How has this project impacted the health status of expectant/ new mothers and their newborn?
4. What is the potential sustainability of the integrated model of enhanced prenatal assessment and care?
5. In what ways would this project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?

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4. **What is the potential sustainability of the integrated model of enhanced prenatal assessment and care?**
5. **In what ways would this project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?**

Each primary question and its supporting secondary questions are discussed in sequence. Summaries of original responses for surveys, interviews, and the Advisory Committee Focus Group are found in Appendices E through H.

Primary Question #1	
To what degree has the project enhanced prenatal psychosocial assessment (PPA) for all expectant mothers on PEI?	
1.1	How were the results of the ALPHA pilot study disseminated, received, and supported by physicians and other health care providers?
1.2	What physicians were educated and how were they educated regarding the process of enhanced psycho-social assessment?
1.3	What educational material were used to educate physicians? (a) Were a reference guide and a referral network resource directory completed by Project staff? (b) Were they provided to physicians during the education process? (c) Were they considered useful?
1.4	What were the barriers and facilitators of implementing the enhanced psycho-social assessment?
1.5	What was the physician knowledge/skill of, commitment to, comfort with, and level of satisfaction with performing the enhanced psychosocial assessment?
1.6	Are physicians completing enhanced psychosocial assessment with all expectant women on PEI? If not, to what degree is this being done? What recommendations do they have to encourage completion of the enhanced psychosocial assessment with all expectant women on PEI?

1.1 How were the results of the ALPHA pilot study disseminated, received, and supported by physicians and other health care providers?

Dissemination of ALPHA Pilot Project: The methods of report dissemination, the reception of the report, and the support offered by physicians and other health care providers are discussed in that order using information extracted from Project staff interviews and documentation notes, the Referral Network Mail Survey, and the Physician Pre-Education Survey.

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Dissemination Methods: As previously noted, dissemination activities surrounding the results of the ALPHA Pilot study have been quite broad to date. According to the Prenatal Psychosocial Assessment Project documents, eight general methods were used to distribute the results of the pilot, which were positive and paved the way for this implementation study. A detailed list of the eight dissemination methods is shown in Appendix I.

The Physician Pre-Education Survey (n=46) conducted prior to the group education sessions indicated that the ALPHA Pilot Report was known to 34 physicians while 11 physicians had not yet heard about ALPHA. Among the physicians who had heard about ALPHA, 28 reported reading about it in print (9; mail-out, pamphlet, article), hearing an oral presentation (15; meeting, presentation, Project staff, physician contact), participating in the pilot study (3; pilot physicians), or else they didn't recall how they heard about ALPHA (1). Only two doctors had incorporated ALPHA into their practice among the 32 doctors who found ALPHA applicable to their practice.

How Report Was Received and Supported: In general, the report generated "extremely positive feedback." Every effort was made to provide the report in a format acceptable to the recipient group. Some out-of-province recipients of the report have sent e-mail messages expressing strong approval for the pilot. In personal interactions with physicians, their comments were very positive. Advisory Committee members provided good public relations and helped to build support for the Prenatal Psychosocial Assessment Project.

1.2 What physicians were educated and how were they educated regarding the process of enhanced psychosocial assessment?

Participants in Education Process: The physicians trained in the administration of the PPA were family physicians and obstetricians. Public Health nurses were also provided with an information session. Their referral network colleagues were also presented information about the assessment. Overall, the health care providers trained represented all five health regions of PEI.

The Advisory Committee, especially the physician members, the results of the pilot study, other family physicians, and the scientifically-based literature informed the PPA Project regarding acceptable ways of reaching PEI physicians. The broad-based Advisory Committee worked collaboratively to develop the model for the physician education component and the model for the integrated service delivery. The family physicians and obstetricians across PEI were the physician target group for the study. It was realized that this was a very ambitious initiative, which would extend beyond the life of the present project.

The method whereby doctors were educated regarding the PPA was developed by the Advisory Committee, as stated above. Their recommendations were considered by the Project Coordinator who proposed a protocol to the Advisory Committee. For the list of considerations that were used to develop the protocol see Appendix J.

Education Process: If "education" is broadly interpreted it can be said that there were five aspects or components to the education process. Included were provider education sessions, project announcement, physician compensation, administration and management, and knowledge building regarding the enhanced Prenatal Psychosocial Assessment.

- **Provider Education Sessions** - As stated previously, the education sessions were conducted over a nine-month period starting in 1999 and finishing in 2000. The Project Coordinator scheduled locally available group sessions across PEI to explain the correct assessment procedures to physicians and Public Health nurses. Sessions were small group at first and later one-to-one presentations were conducted in the physician's office. Experience taught that it was necessary to seek innovative ways to reach busy physicians.

- **Project Announcement** - The informal education, or as others might say, the public relations process, was a continuation of the modus operandi that had been beneficially used during the ALPHA pilot study. In 1999, informal education sessions were provided to hospital perinatal committees. In the summer of 1999, letters were sent to family physicians informing them about the Project. The background for the project was also built through oral presentations in December of 1999 when Project staff met with the Family Practice Committee at one hospital informing them that the Project involved all family physicians, even those not routinely providing prenatal care. The Medical Society newsletter was also used to inform physicians province-wide. Information was provided to physicians' office staff regarding their role in booking appointments for women to return to have the assessment completed. As part of formal physician education, a training video was made available for those receiving group and one-to-one sessions. As of the summer of 2000, Project staff made 56 presentations: 9 Public Health Nursing sessions, 15 physician group sessions and 32 one-to-one physician sessions so that 78 out of 80 physicians (98%) had been reached.

- **Physician Compensation** - In March of 1999, the Project Coordinator met with the Provincial Medical Director to discuss the Project, including physician remuneration. The Advisory Committee forwarded a letter to the Joint Consultation Committee in June of 1999 asking for physician compensation. As well, this issue will be addressed in the next round of physician negotiations with respect to an increase in the fee structure for counselling and the ability to bill along with a regular prenatal visit. Hence a compensation plan was in the

making. In addition to monetary compensation, CME credits were approved by the College of Family Physicians for attendance at the education sessions.

- **Administration/Management** - In April of 1999, the Advisory Committee decided that family physicians and obstetricians should be approached to take on the enhanced assessment, and that a physician would co-chair the Advisory Committee. All physicians who were interviewed received PPA information and resources to assist them in the administration and management functions associated with the assessment.

- **Knowledge Building** - The Project can be regarded as having a knowledge development or knowledge building feature due to the training and the knowledge creation. That is, the provincial testing of the psychosocial model of assessment will generate new knowledge to inform and advance psychosocial assessment in PEI and elsewhere. During May through June of 2000, the East Prince and West Prince physicians participated in a post-implementation telephone interview, while Queens, Southern Kings, and Eastern Kings physicians shared their experience similarly in September to October 2000.

1.3 What educational materials were used to educate physicians?

Introduction: To train the physicians, an education package and training session were developed so that the Project Coordinator could educate the primary delivery agents in the protocol to be followed. Evaluation was conducted to ascertain the usefulness of the training materials and the sessions.

Education Session and Materials: The first education session was conducted in November 1999. It was August 2000 before the sessions were complete, and the training is ongoing since physicians establish new practices in the province and therefore must receive training in the enhanced Prenatal Psychosocial Assessment. For a detailed description of the Education Resource Package see Appendix K.

Perceptions of Education Process: When the Physician Telephone Interview was completed after physicians began implementing the enhanced assessment, all physician (n=35) respondents and one of two Public Health nurses were satisfied with the education sessions that had been conducted by the Project Coordinator. Among respondents, 92% (34/37) found that the resources met their needs. This figure may be slightly underestimated since two physician respondents refrained from answering having not yet used the new assessment.

1.4 What were the barriers and facilitators of implementing the enhanced psychosocial assessment?

Considering the complexity and the numerous steps required to implement and integrate a new program across an entire province, it was important to study the facilitators and barriers so that the PEI experience could be shared with other jurisdictions. The relevant data were obtained through all of the data sources listed in Table 1. Lists of facilitators and barriers were compiled and are presented below. They are not listed in any priority order.

Facilitators

- Use of appropriate methods to reach target groups
- Small geographic size facilitates travel, communication, meeting goals, etc.
- Nature of established interpersonal relationships on PEI
- Support of all relevant disciplines within the broader health system
- Ample resources for travel, Project materials, etc.
- Efforts to involve service providers in the process
- Availability of quality pilot study results and short report/executive summary
- Desire to provide holistic care for clients
- Working towards stated deadlines
- Practitioners able to link to referral networks
- Having Project champions
- Confidentiality of prenatal client information in physician files
- Physician trust of Project and its aims
- Ready access to French language translators
- Empowerment of expectant women through their participation in PPA
- Availability of evidence-based assessment tools
- Addressed a timely topic which was part of Family Violence Initiative
- Knowing the Project could make a difference in the lives of women and children

Overall, the Prenatal Psychosocial Assessment Project was considered do-able. In the words of one interviewee: *"...based on front-line reality, it's not something that's beyond the comprehension or the do-ability of the people providing the service."* In other words, it was possible to surmount the barriers that are listed below.

Barriers

- Limited time on the part of physicians
- Offices needing to iron out a few kinks
- Having to work province-wide was a challenge at times
- Physicians unaware of the urgency in regards to the limited time frame for the Project

- Difficulty in Coordinator accessing physicians
- Offices forgetting to make women's appointments for assessments
- Overflowing service loads with limited capacity to add clients, i.e., Community Mental Health
- Circumstantial barriers, i.e., poor weather, holidays, death, flu season
- Having no control over the motivation of prenatal clients
- Inadequate remuneration for physicians
- Physician practice of making referrals, i.e., limited referrals
- Lack of physician comfort with interview process
- Limited appreciation and knowledge of prevention
- Additional paperwork/forms amidst a busy schedule
- Late booking of first prenatal visit
- Misunderstanding regarding appropriate person to complete assessment
- Length of time between education session and implementation in some cases
- Not being able to bill with a regular prenatal visit

Overall Perspectives About Facilitators and Barriers: The facilitators and barriers differed somewhat depending on whose perspective was taken. However, it appears that key facilitators were supportive people whether Project champions, Project staff, or cooperative physicians, who not only supported the innovation themselves but were capable of being adaptable and eliciting support for innovative undertakings. After all, people make things happen. Among the barriers were having inadequate work time and physician remuneration along with procedural confusion associated with the first time use of a new assessment procedure (both process issues and assessor issues). To illustrate, in the Physician Telephone Interview, lack of time was the foremost barrier having been the first barrier to come to mind and the barrier mentioned most often (50% of total mentions; 30 of 60 mentions). It is important to note that there was limited space for managing the barriers, i.e., the size of physician caseloads demanded that physicians effectively manage their practices to work another task into an already busy schedule.

Value of Multiple Perspectives: This implementation study was a good example of why qualitative field notes or logs are important to evaluation and research. Specifically, the Project Coordinator documented the broader barriers and facilitators, which were operating at various levels - community, societal, and professional. The Project Coordinator cited the negative impact of barriers such as workforce stress increased by physician death in an already overworked medical community, physician resource issues regarding recruitment and retention, flu season and long waiting lines for physician care, and bad weather for winter travel, etc.

How were the barriers managed?

- Project Coordinator was extremely flexible to meet schedules/needs of all providers;
- Respect and appreciation was shown for people committing to the added responsibility;
- Remuneration was secured for the physicians;
- Willingness was shown to fit new services into already tight schedules; and
- Flexible arrangements were permitted, e.g., family physician assesses but may choose not to and have completed by obstetrician or PHN.

How might these barriers have been avoided?

- Ensure physician remuneration in advance of study (an impossibility with short funder time line);
- Enhance physician to patient ratio to facilitate physician involvement in initiatives such as this;
- Implement the Project on a regional or local rather than provincial level; and
- Allow more time to plan Project between approval and completion.

1.5 What was the physician knowledge/skill of, commitment to, comfort with, and level of satisfaction with performing the enhanced psychosocial assessment?

Overwhelmingly, the physicians have the knowledge, commitment, comfort level, and philosophical support to use the PPA. Some non-agreement was due to not yet having used the tools. Overall, the PPA was well supported in theory and practice.

According to the Physician Telephone Interview results presented in Table 2, the 35 physicians and two Public Health nurses interviewed (n=37) were overwhelmingly supportive of the PPA . Measurement of four indicators of physician preparedness before the education session and after the 1-3 month implementation period indicated that for all four indicators, the percentage of positive responses increased: i.e., knowledge (43% vs. 84%); commitment (54% vs. 73%); comfort (54% vs. 78%);

and support (85% vs. 89%). This is a very positive result and bodes well for the education sessions' effectiveness as well as the value of actually completing the assessment.

Table 2. Physicians' Reported Knowledge, Commitment, Comfort, and Support for PPA Pre-Education and Post Implementation

Measure	Time	Agree	Neither Agree nor Disagree	Disagree	Missing or Not Applicable	Total*
Knowledge about how to perform PPA	Pre	(43%) 20	9	16	1	46
	Post	(84%) 31	2	2	2	37
Committed to incorporating PPA into practice	Pre	(54%) 25	15	4	2	46
	Post	(73%) 27	3	5	2	37
Comfortable performing PPA	Pre	(54%) 25	9	11	1	46
	Post	(78%) 29	2	2	4	37
Supportive of PPA	Pre	(85%) 39	6	1	0	46
	Post	(89%) 33	3	0	1	37

*** Sample size varies between pre and post measures; N=46 vs 37 respectively.**

At least a portion of the neither agree nor disagree and the not applicable responses are attributable to persons who had not yet used the PPA and therefore did not commit positively or negatively to the question. Therefore, only the disagree column is of real concern in this early evaluation of PPA use. Knowledge and comfort measures were each of concern for two persons or 5% of the respondent population so that additional training could be considered for these persons. Five persons (14% respondents) disagreed with incorporating the PPA into their practice for reasons related to time and role appropriateness. It is possible that these were the obstetricians who were not the designated assessor according to the PEI PPA Model.

Most importantly, none of the respondents disagreed with the concept of the PPA. Therefore, any disagreement with incorporating the PPA into practice revolves around the implementation process and not the idea of the PPA itself. The findings suggest that the initial training session was required to increase knowledge, commitment, and comfort rather than to convince them of the value of the PPA or the importance of it in their practice.

1.6 Are physicians completing enhanced psychosocial assessment with all expectant women on PEI?

Assessment Compliance Rates: According to the Physician Telephone Interview, one-half of the physicians interviewed had already performed the PPA (17/35) and among the 17 users, 16 had used the PPA from 1-5 times (only one person reported using the PPA more than five times, i.e. 6-10 time category). Therefore, the majority of physicians were in compliance with (or supported) the PPA protocol.

Reasons the PPA was not completed by physicians included: 1) having lost track of patients after they were referred to obstetrician for prenatal care; 2) the problem of booking time for PPA; 3) women not returning for assessment according to scheduled appointment; and 4) doctor has given form to woman to be completed at home but either appointment time has not arrived or clients are not interested. It is stressed that the PEI Prenatal Psychosocial Assessment Model specifies that the self assessment is to be completed at the physician's office, rather than at home because of the sensitivity surrounding some questions. It is reported that some physicians are not following the protocol, which usually occurs as part of testing and implementing a new program.

Future Plans: With regard to physician policy or plans to complete the PPA, the Physician Telephone Interview indicated a strong belief in the value of performing the PPA. The majority (80% or 28/35) of physician respondents, already used or planned to use the PPA with pregnant women in their practice. Nine persons did not give a "Yes" answer. Judging from their later comments, it was because they had not yet tried the PPA and therefore refrained from making any judgments regarding its relevance and effectiveness in addressing psychosocial issues among their prenatal clients.

Misunderstandings in Implementation Need to be Addressed: One doctor was referring to the specialist because he thought that the specialist was the fastest and best person to do the PPA. Two doctors indicated that their nurse or assistant was assessing and the physician was overseeing the assessment, and one doctor noted that 16 weeks is not much time and that he often forgets to re-book patients for the PPA. As well, women were filling out the form at home, a violation of protocol as noted earlier.

Project-Induced Changes in Practices Using the PPA: The majority of responses were "no change" when all responses to the relevant indicators were tallied (118/185). This was likely due to the short 1-3 month time period between implementation and evaluation and therefore the lack of opportunity to observe the outcomes from using the PPA among their prenatal clients. Almost one-fifth (42/185 responses) indicated an increase especially in the areas of: 1) increased awareness about referral services; and 2) communication both with regard to the frequency and the quality of communication with their clients. It is very notable that no decreases were reported in any of the five indicators measured. Approximately 10% (25/185) of responses were "not applicable" primarily due to obstetrician respondents, as they were not the designated assessor in the PPA Model.

Prenatal Clients PPA Refusals: If the respondents had completed an assessment, they were asked if their clients had refused referrals. Among women who were recommended for a referral, there was a 2:1 ratio of acceptors to refusers (10 vs. 5 women). Therefore, at this early stage of implementation the response among the target audience is positive. Some physicians indicated that the reasons for refusing were: 1) not wanting to attend prenatal classes; 2) Public Health nurses already referring the woman to services such as nutrition, which could be ascertained early in pregnancy; and 3) in one case a woman refused intervention and wanted to change physicians after being told that she should examine and change her illicit drug behaviour.

Interventions Induced by PPA: Interventions arising from the use of the PPA to date as cited in interviews included: 1) nutrition counseling in two cases; 2) mental health and stress counseling in two cases; 3) smoking cessation in two cases; 4) relationship issues in two cases; 5) breast-feeding in one case; and 6) promotion of healthy lifestyle in one case. Beyond general prenatal counseling one user noted that a confidential call was made to the obstetrician regarding a "delicate issue". While all reasons fit the range of health care issues to be addressed by the PPA, it is very gratifying that the psychosocial issues such as mental health, stress, relationship, and the "delicate issues" could be addressed by implementation of the PPA. As noted earlier, the Referral/Communication forms tracked referrals and six forms were returned to the Project Coordinator. Undoubtedly, the examples refer to some of the same clients.

Primary Question # 2	
To what degree has the project led to an appropriate and integrated response to identified psychosocial needs or risk factors?	
2.1	Was a model of integrated service delivery developed by Project staff? (a) What was this model? (b) What process was involved in its development?
2.2	What are the barriers and facilitators of involving physicians and their referral network in an integrated model of service delivery?
2.3	How have communication and intervention processes among the referral network changed as a result of enhanced psychosocial assessment and integration?
2.4	How has enhanced psychosocial assessment and integration affected client access to care?
2.5	How has enhanced psycho-social assessment and integration affected duplication of services?
2.6	What is the level of satisfaction of physicians and other members of referral networks with the integrated model of assessment and service delivery? Are additional training/supports required?
2.7	What is the level of satisfaction of clients with the integrated model of assessment and service delivery?

2.1 Was a model of integrated service delivery developed by Project staff?
(a) What was this model?
(b) What process was involved in its development?

Development of the Model of Integrated Service Delivery: The Model of Integrated Service Delivery was constantly subject to revision starting with the pilot ALPHA Model. The final version of the model, indicating the flow of referrals among prenatal service providers, is shown in Appendix B. Also provided are the guidelines for use of the assessment model. It is important to note that the model had to account for the fact that a high percentage of family physicians on PEI do not do prenatal care. Appointments are booked by office staff (primarily obstetrician staff) for women to return to their family physician to have the assessment completed at approximately 20 weeks gestation. If the family physician is one who provides prenatal care, the woman would be booked in for an additional appointment at approximately 20 weeks. Having the appointments

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booked rather than leaving it up to the women to make their own appointments was viewed as a way of increasing compliance.

Facilitators and Barriers to Model Development: A broad range of facilitating factors were noted which undoubtedly accounted for the broad-based support received by the Project. Specific facilitators included:

- Broad composition and role of the Advisory Committee;
- Commitment and participation of the Project Co-ordinator, Family Violence Consultant and other Project champions;
- Results of the ALPHA Pilot Study (evidence of need/want, credibility for the issue and practical suggestions), and the availability of the ALPHA tools;
- Early negotiation of a Medicare Fee Schedule;
- Relatively slow change over time with good communication and consensus of involved parties;
- National recommendations made by the Society of Obstetricians and Gynecologists, the College of Family Physicians, and the recently issued National Family-Centred Maternal Newborn Guidelines;
- Established relationships, which increased approachability of potential colleagues;
- Timing of the Project given past pilot prenatal assessment work; and
- Belief in a broader interpretation of the medical model, i.e., a bio psychosocial model.

The "slow but sure" approach was used by the Advisory Committee. It was well summed up by one Focus Group participant who said: *"We are trying to take it slowly and I think that's the key, if you push people too quickly, especially when they have heavy workloads, it just becomes an added stressor and it doesn't move too quickly."* Unfortunately the short project and evaluation time lines were seen as a deterrent to this slow but sure approach. One person noted *"...it's making us maybe move quicker than we would like to move with it and we hope that's not going to interfere with it in the long run."*

Barriers: These slowed progress towards model implementation. Barriers were cited and were very real, but compared to the magnitude of the cooperation received and the eventual health benefits, the barriers were small by comparison. Documentation cited the barriers as including:

- External time lines pushed too hard for Project task completion;
- Lack of appreciation for the time required to start such a large innovative project;
- Existence of another federally funded project in one health region, which was modified and changed in focus and might result in a potential for overlap of assessment and service.

2.2 What are the barriers and facilitators of involving physicians and their referral network in an integrated model of service delivery?

During the Physician Telephone Interview, which was conducted 1-3 months post-implementation, the doctors were asked "What was it like to apply the assessment into your practice?" Being "pressed for time" was a common theme in doctors' answers. Time to complete the Prenatal Psychosocial Assessment was the biggest barrier. Some doctors asked the woman at 16 weeks of pregnancy to complete the form at home and bring it to the next appointment to save office time (a suggestion rejected by the Advisory Committee for fear that it would have a negative impact in several ways), while other doctors asked their office or nurse assistant to help collect the information from the prenatal client. Other problems specific to the physicians and the referral network were:

- Forgetting to book the time to complete the assessment;
- Women not returning for the appointment;
- Making time for the added appointment in a busy practice;
- Client curiosity regarding reason for doing the PPA;
- Developing interview skills and learning how to deal with sensitive topics; and
- Cultivating patient rapport.

In short, physicians cited time constraints, interviewing skills, and finding ways of increasing efficiency of the enhanced assessment as issues to be addressed. For a full list of facilitators and barriers refer to pages 14-15, which includes the broader societal level facilitators, e.g., Coordinator flexibility, Project champions, record of success and barriers, e.g., doctor shortage, flu season, travel times, which were identified during the Project.

2.3 How have communication and intervention processes among the referral network changed as a result of enhanced psychosocial assessment and integration?

As noted earlier, any disagreement with incorporating the Prenatal Psychosocial Assessment into practice revolved around the implementation process and not the idea of the assessment itself. The initial training session was required to increase knowledge and comfort levels (skills) among physicians moreso than to convince doctors of the value of the assessment or the importance of incorporating it into physician services (Physician Telephone Interview).

Approximately one-half of doctors reported an increased awareness in the roles of various service providers, while the remainder reported no change. A few doctors

reported an increased number of referrals but the majority reported no change. The comments suggested that physicians expect that the number will increase through time. The frequency and the quality of communication between doctor and clients was reported to be increased in a few cases but the majority reported no change in communication patterns. Lastly, the ease of patient access to service was basically unchanged.

The two Public Health nurse respondents to the Physician Telephone Interview each reported no change in referrals to or from their agency as a result of the new protocol, possibly due to the small number of pregnant women referred or the pool from which they would draw. According to Referral/Communication forms, referrals made by physicians/PHNs included a psychiatrist (depression), PHN (prenatal classes, smoking cessation, Best Start), Community Nutrition, and Community Mental Health (depression and stress). Due to the small numbers of referrals made in the short implementation to evaluation time frame, no changes were noted by referral agencies in the Referral Network Mail Survey.

2.4 How has enhanced psychosocial assessment and integration affected client access to care?

Access to care was basically unchanged, with only three of 37 providers reporting an increase in access to care. Twenty-six reported no change and 8 reported not applicable (possibly because they had not yet used the PPA). The short time frame between implementation and evaluation has impacted on this.

2.5 How has enhanced psycho-social assessment and integration affected duplication of service?

More than one-half of the respondents (23/37) were satisfied with the streamlined referral process. The remainder (14/37) did not commit: 1) having not used the PPA yet; and/or 2) thinking another person/role should complete the PPA. No mentions of duplication of service were noted. One respondent indicated that much of the information asked in the PPA is covered by PHNs in their initial assessment and indicated that it would be interesting to learn how they feel about the tool. Another noted that it would be of greater value when the physician follows the patient throughout pregnancy. It is possible that the small number of PPAs completed to date by the 17 users has obscured any duplication that exists.

2.6 What is the level of satisfaction of physicians and other members of referral networks with the integrated model of assessment and service delivery? Are additional training/supports required?

The majority of physicians were satisfied with the new PPA (29/35), no one was dissatisfied, and almost one-quarter (8/35) were neutral or thought it not applicable to their medical practice probably due to not having used the PPA yet or thinking it should be referred to another professional for completion. The tool was described as holistic and multidisciplinary in approach. It was suggested that at least one doctor had already tried such an innovation on his/her own and was pleased to see it formalized. One respondent suggested that the PPA schedule be shortened if possible. Referring patients back to their family physician appeared to be a part of the procedure that requires more attention as time, practice, and role-related issues are worked through. It was noted that some users viewed the PPA as a "guide" rather than a rigid interview or assessment schedule. Lastly, one respondent suggested that a general version of the form be developed for use with all patients. Overall, the comments were very constructive and supportive of the PPA. It appeared to be an assessment whose time had come, especially since it provided a more complete picture of the client with which the physician could work to improve the service offered to clients.

Should the PPA be continued? Clearly, the majority of respondents, 31 of 37, thought that the PPA should be continued. Only one person dissented. The question was not applicable to five respondents due to their not having completed the PPA or thinking it should be completed by another service provider. The need for psychosocial assessment was articulated and strongly supported by several respondents. The comments suggested that there is a learning curve as health care providers refine their skills in asking personal questions, but that the outcomes for client health and physician care make it a worthwhile venture. Overall, experience was limited but the potential for improved patient outcomes was obvious from the synthesis of comments.

By placing a value on initial training and raising issues, respondents may be indirectly suggesting that additional training would be of assistance in answering questions and reducing problems, especially now that all stakeholders have had an opportunity to gain some familiarity with the tool and the process.

2.7 What is the level of satisfaction of clients with the integrated model of assessment and service delivery?

If clients are satisfied then the doctor is more likely to be favorably predisposed to start and/or continue the assessment. According to the doctors who had used the PPA, client satisfaction was rated positively by 14/17. The remaining physician users may not have replied on behalf of their patients due to lack of experience using the new tool, so that the satisfaction figure may even be an underestimate. The majority opinion was that the enhanced assessment was a valuable tool. Among the respondents, only one physician indicated that his patients felt the assessment wasn't satisfactory. Responses, especially Public Health nurse responses, indicated that over time issues would be raised during the course of visits and that the overall quality of health care

would be increased including psychosocial care, i.e., more holistic health care. Users indicated that the enhanced assessment provided more patient information to help them better serve their clients.

Primary Question # 3
How has this project impacted the health status of expectant/new mothers and their newborns?
3.1 What health benefits for (a) expectant and new mothers, (b) their newborns, (c) and their families are perceived as a result of this project?
3.2 What were the unintended health impacts of this project for (a) expectant and new mothers, (b) their newborns, (c) and their families?
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3.1 How has this project impacted the health status of expectant and new mothers (prenatal & postnatal)?

The consensus opinion was that it was too early to say for sure how mothers' health status was improved with only 1-3 months experience with implementation. The process to date has already increased environmental receptivity or opened the door for better communication. The extra psychosocial information gathered was deemed useful in better understanding a client's life situation. The Public Health nurses stressed the actual and potential benefit of early identification of problems specific to the prenatal

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period or to the client situation in general. The annual reports from the PEI Reproductive Care Program Perinatal Database are testimony to the volume of issues to be addressed and the potential for system savings.

3.2 How has this project impacted the health status of newborns?

With a short study period of 1-3 months and the fact that no babies were born at the time of evaluation, it is too soon to state the benefit with reliability. From the PEI Reproductive Care Database Annual Reports clearly there are benefits to infants if situations such as low birth weight, Fetal Alcohol Syndrome, etc. can be prevented or reduced. Nurses noted that prenatal intervention is important because time is so limited after the baby is born.

3.3 What health benefits for

(a) expectant and new mothers,
(b) their newborns,
(c) and their families
are perceived as a result of this project?

As outlined in the responses above, the respondents thought that they had not had enough time to evaluate the ultimate or even short-term outcomes on the health and well being of the expectant and new mothers, their babies, or families. At this time, there has been no change identified. One respondent commented that women felt more of an ability to talk with their physician about psychosocial issues, and one physician indicated these issues are now "*more forward in the mind of the physician*" when dealing with non-pregnant patients, i.e., all patients. The nurse respondents stressed the prevention potential inherent in the PPA.

3.4 What were the unintended health impacts of this project for

(a) expectant and new mothers,
(b) their newborns,
(c) and their families?

Additional comments regarding the PPA were generally positive and in support of the Project and the work it's trying to accomplish. Physicians were interested in feed back on the Project and also identified that it has heightened their awareness to psychosocial factors. Issues in the assessment are now more forward in the mind of the physician. They see it as a tool that could be adapted to use for all patients in their care. In fact, one doctor asked for a modified version of the PPA for use with all patients.

Primary Question #4	
What is the potential sustainability of the integrated model of enhanced prenatal assessment and care?	
4.1	What are the one time and sustainability costs of the project? (a) What is the one time cost associated with the development of the enhanced assessment and integrated service delivery model? (b) What are the predicted annual costs associated with sustaining this project?
4.2	What were the changes in resource utilization by expectant and new mothers and their newborns, and its associated cost to address psychosocial risk factors identified by the enhanced psychosocial assessment?
4.3	What potential do enhanced psychosocial assessment and integration of services have for cost savings/containment?
4.4	All things considered, what is the rationale for continuing the enhanced psychosocial assessment and integrated service delivery model?

4.1 What are the one time and sustainability costs of the project?

(a) What is the one time cost associated with the development of the enhanced assessment and integrated service delivery model?

(b) What are the predicted annual costs associated with sustaining this project?

The one time costs included the following considerations (Focus Group Report):

- Having previous funding to conduct a pilot reduced costs at present stage of development of Project;
- HTF funding to cover Project costs and Medicare coverage for physician fee was essential;
- The PPA Project was not a costly project as referral network staff were funded through Regional Health Services (regular work and thus did not have to be paid by the Project); and
- In-kind support provided by the Department of Health and Social Services assisted greatly, e.g., production of Project materials, administration costs, use of existing organizational structure/infrastructure.

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The predicted annual costs include physician remuneration and referral network expenses such as staff time, overhead, and program costs.

The Medicare Physician Remuneration schedule is as follows:

Fee Code	Professional Service Remuneration	
2505 Health Pro	Counselling up to 20 minutes	$19.35
2506 Health Pro	Counselling for over 20 - 45 min.	$23.20

With an average of 1500 births per year, the cost of providing the PPA to all pregnant women on PEI can be estimated to be 1500 multiplied by $19.35/20 minute session, which yields an estimated cost of $29,025.00, or approximately $30,000 per year.

The total cost depends on the number of referrals made and the complexity of the situations addressed. However, it is important to remember that the costs are offset by prevention of severe disorders or developmental difficulties that are chronic and oftentimes expensive to treat. The overhead, administrative, and indirect costs, e.g., patient travel, special products, and disease-specific care, are not included due to the complexity of calculating them. The sample of prenatal clients in this study is too small to reliably estimate true costs that would be incurred in the long-term with routine psychosocial assessment. However, if abuse can be prevented or if mental health can be restored to the mother of the family much preventive work will already have been done for the children in the family. The exact pay-off profile may occur over part or all of the life cycle with the exact pattern or time of pay-off depending on the condition/situation prevented.

4.2 What were the changes in resource utilization by expectant and new mothers and their newborns, and its associated cost to address psychosocial risk factors identified by the enhanced psychosocial assessment?

To even estimate the impact on resource utilization it was necessary to examine the number and type of referrals that were logged during the 1-3 month implementation period. As noted earlier, the tracking forms cited referral agency and reason(s) for referral(s), which included the following:

- Psychiatrist (depression);
- Prenatal Classes (refresher);
- Smoking Cessation;
- Best Start (parenting program offered by CHANCES);
- Community Nutrition; and
- Community Mental Health.

What can be said about costs?

- This list contains existing services so no developmental costs are required.
- Some services may be individual and some may be group offerings.
- Severity of condition/situation when detected and duration of treatment or care are determinants of total costs.
- Persons able to use group services would cost less than clients requiring more expensive one-on-one services.
- All referrals to date have been available through existing health and social services thereby making use of existing rather than new services.

4.3 What potential do enhanced psychosocial assessment and integration of services have for cost savings/containment?

Upstream prevention work should pay extremely well in the long run. Moreover, the strong maternal-child emphasis complements the Early Childhood Development Initiative underway in PEI so that the impact may be synergistic. By employing strong public health interventions, it is hoped that new behavioral norms will be integrated into the culture thereby enhancing the value of the enhanced psychosocial assessment.

4.4 All things considered, what is the rationale for continuing the enhanced psychosocial assessment and integrated service delivery model?

The concluding voluntary comments reflected support for the PPA but concern for the: 1) time to assess; 2) length of tool; 3) provider compensation; and 4) province-wide annual workload to assess all prenatal clients. Overall, the comments were supportive so these issues are just part of implementing a new program to the point where the processes or procedures are acceptable to all persons concerned. Physicians indicating the assessment should be continued elaborated on the fact that the issues addressed are important and should remain an area of concern. It is when problems or issues are identified, something can be done about them. It was said: "*The problems just won't go away*". This initiative will also be of benefit to our younger population to face the future knowing the help that's available should they need it. If the physician makes a concerted effort to apply it, the assessment can be of benefit to the patient and should continue. The value of this HTF-sponsored enhanced psychosocial assessment implementation study was summed up by one person who said: "*It will make us change our practice.*"

Primary Question #5 **In what ways would this Project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?**	
5.1	How can new users of the model ensure successful adoption? (a) What system prerequisites were needed for the success of this project? (b) What obstacles to success were encountered? (c) How might they have been avoided?
5.2	Describe model transferability and generalizability. (a) What elements of this project seem particularly transferable to other regions/ jurisdictions/ programs/ settings? (b) How generalizable is the project?
5.3	What were the unintended effects/outcomes of this project? (a) Positive (b) Negative (c) Neutral
5.4	What resources were created that could be used to transfer learnings to other regions/jurisdictions/programs/settings?
5.5	What would assist transfer of model and learnings to other situations?

5.1 How can new users of the model ensure successful adoption?

(a) What system prerequisites were needed for the success of this project?

(b) What obstacles to success were encountered?

(c) How might they have been avoided?

System Prerequisites: Focus Group participants and survey/interview comments indicated that numerous system prerequisites were essential for the success of this project. The Focus Group findings are summarized in Table 3. Comments and responses to other questions asked during the evaluation confirmed these findings.

Primary Question #5 **In what ways would this Project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?**
5.1 How can new users of the model ensure successful adoption? (a) What system prerequisites were needed for the success of this project? (b) What obstacles to success were encountered? (c) How might they have been avoided?
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5.1 How can new users of the model ensure successful adoption?

(a) What system prerequisites were needed for the success of this project?

(b) What obstacles to success were encountered?

(c) How might they have been avoided?

System Prerequisites: Focus Group participants and survey/interview comments indicated that numerous system prerequisites were essential for the success of this project. The Focus Group findings are summarized in Table 3. Comments and responses to other questions asked during the evaluation confirmed these findings.

Table 3.
What system prerequisites were needed for the success of the Project?

Category	Pre-requisite
People	▸ Project champions and committed decision-makers ▸ Multidisciplinary team ▸ In-kind system contributions (human and monetary)
Funding	▸ Previous pilot study ▸ Present HTF funding ▸ In-kind , e.g., facilities, programs, staff/referral network
Communication	▸ Essential to inform primary stakeholders ▸ Flexibility in dealing with limited availability of people ▸ National recognition by professional organizations ▸ Prepared education package for enhanced assessment
Procedures	▸ Quality work, sustainability and universality ▸ Well established perinatal database ▸ Positive peer-pressure/joint effort/adaptability ▸ Use of regular or routine clinical procedures Paving way for universal psychosocial assessment ▸ Physician remuneration
Context	▸ Completed pilot increased acceptance ▸ University of Toronto involvement aided acceptance ▸ Timeliness of topic ▸ Project being converted to program ▸ Effectiveness raised staff anticipation and morale ▸ Multidisciplinary Advisory Committee ▸ Champions part of Advisory Committee ▸ Past experience working with physicians was valuable ▸ Remuneration as recognition for service and commitment ▸ Client group liked and supported the PPA/Project

Obstacles: The obstacles to implementation success, as discussed in the Focus Group, are listed in Table 4. The first five barriers were material or financial nature while the remaining two barriers were non-material and included client motivation and circumstantial or seasonal barriers.

Table 4. What obstacles to success were encountered?
▸ Repeated time, travel, and costs to work province-wide
▸ Tight time lines and some parties unaware of how tight time lines were
▸ Physician attitude of "one more thing to do in an already busy schedule"
▸ Difficulty in Coordinator accessing physicians
▸ Services perceived to have limited capacity to take more clients
▸ Having no control over the motivation of the client
▸ Circumstantial barriers, i.e., poor weather, holidays, death, and flu season
▸ Concern that conditions/situations would be diagnosed that could not be treated/dealt with
▸ Concern that referrals would not be made, as specified by the PPA protocol

Avoiding obstacles: All obstacles were anticipated in advance of the Project implementation once the time line was known. From the outset it was known that with a physician shortage and lack of time to negotiate a physician compensation package that securing physician cooperation would be a challenge. This was met by being extremely flexible in developing training and implementation protocols that fit physician work styles. Alternative approaches could have been taken, but each approach has advantages and disadvantages, and may not have been any better than the chosen approach. The time was tight due to the Health Transition Fund time line. Lastly, having referral networks addressed the problem of having referrals made.

Table 5. How might the obstacles have been avoided?
▸ Physician remuneration arranged prior to Project
▸ Reasonable physician workload
▸ Smaller scale of implementation
▸ More lead-time for Project planning

5.2 Describe model transferability and generalizability.

(a) What elements of this project seem particularly transferable to other regions/ jurisdictions/ programs/ settings?

(b) How generalizable is the project?

PEI Model Transferability: When asked if they believed that the model was transferable, Focus Group participants indicated that "it depends". All of the six general categories of elements are potentially transferable (model, human resources, remuneration, assessment tools, physician/referral network, education materials, referral process, reports, and the context). Whether they are actually transferrable depends on the configuration of the same six elements in the recipient region or province. With favourable circumstances the PEI program elements could be transferrable.

Elements of Project that Seem Particularly Transferable to Other Regions/ Jurisdictions/Programs/Settings: There were no single elements that were specified as transferable. Instead, the Prenatal Psychosocial Assessment must be transferred as an entire package because it is considered to be 'bare-boned', with all elements being critical and basic to the Project. Overall, all elements are potentially transferable, though possibly in a modified form. These elements may look different in PEI because of its small size, ability to travel the entire province, having previously established relationships with contacts, and the nature of the PEI service delivery system.

Several key issues were identified as important in getting this project up and running. As a result it was thought that this information was an important aspect of transferring the PEI model to other settings. Examples are:

- Champions are the determining factor in the Project's success;
- Selling the Project to various players to gain their participation is critical; and
- Remunerating physicians is essential.

Project Generalizability: Focus Group participants indicated that the outcomes are likely to be generalizable to the extent that the elements of the intervention are transferable and are implemented in accordance with the model. If the setting allows this type of service, then the results seen here are potentially generalizable. As one Focus Group participant noted, "By introducing universal PPA we are changing a standard of prenatal care in the province." It was also suggested that with adaptation, the assessment tools could be used with other client groups.

Focus Group members also stated that the PEI Package should be adopted as a total package (rather than adopting only certain pieces of the package) as it is the basic package that is required to do the job. The considerations regarding generalizability included the following:

- Service delivery set up (including existence of providers or network);
- Whether the cultural background is conducive to compliance with PPA;
- Physician remuneration;
- Referral process (establish process and network before starting training);
- Geographic size/travel scope;
- Permission from ALPHA Team to use or alter assessment tools;
- Existence of midwives;
- Process of getting information to and cooperation of physicians;
- Ratio of obstetricians to family physicians; and
- Amount of overall and dedicated human resources ("*If you didn't have one person designated, it wouldn't happen*" said one person of the Project Coordinator position);

According to the Focus Group results, potential users of the PEI Prenatal Psychosocial Assessment include:

- Health Canada including the Health Transition Fund Secretariat;
- Advocacy organizations, e.g., Status of Women;
- Community organizations, e.g., CHANCES, Transition House Association;
- Referral network agencies;
- National professional organizations, e.g., College of Family Physicians;
- All physicians; and
- All clients.

5.3 What were the expected or intended outcomes and unintended effects/outcomes of this project? (a) Positive; (b) Negative; and (c) Neutral.

Among the expected outcomes of the Project listed in Table 6, it was items 1-13 that were accepted by Focus Group participants (as prompted or suggested by the researchers) as being potential or real outcomes. These items were considered to be generalizable to other jurisdictions. Items 14-16 were added by the Focus Group participants as unexpected outcomes that had resulted from the Project or would potentially result in the future. All outcomes, expected and unexpected, were considered to be positive and generalizable for: 1) the pregnant woman; 2) the service providers; 3) the families; and 4) potentially other client populations.

Of specific importance to the group were the following top three intended outcomes, which are listed in their order of significance as ranked by the Focus Group: 1) improved health of Island mothers and their infants (#13); 2) physicians more comfortable with Prenatal Psychosocial Assessment (#2); and 3) more interventions/referrals made for psychosocial issues of pregnant women (#8) as reinforced by the comment: "*...more case finding when you start asking...*".

Table 6 also cites unintentional outcomes, namely, client comfort, doing good, and generalization of the assessment to other patients (Items 14-16). All three unexpected outcomes are very significant in terms of client care.

Table 6. Expected or Intended Outcomes of the Project (Real or Potential)

1	Physicians are more aware of PPA
2	Physicians are more comfortable with PPA.
3	Physicians are more committed to PPA.
4	Physicians are more skilled in performing PPA.
5	Physicians are completing PPA with all pregnant women.
6	Prenatal records are more complete.
7	Referral networks have been established in each health region.
8	More interventions/referrals made for psychosocial issues of pregnant women.
9	More collaboration within the prenatal care delivery system.
10	No omissions services within the prenatal care delivery system.
11	More timely response to the psychosocial needs of pregnant women.
12	Improved quality of intervention/service for pregnant women.
13	Improved health of Island mothers and their infants.
14	Increased client comfort in discussing these issues.
15	Satisfaction from 'doing good' for the client and society.
16	Generalization of assessment to other client groups.

5.4 What resources were created that could be used to transfer learnings to other regions/jurisdictions/programs/settings?

The following are the resources suggested by Focus Group participants that could be used to transfer learnings.

- The Prenatal Psychosocial Assessment Model
- The willingness to participate in a socially worthwhile project
- The PEI friendly version of the PPA tools and PPA Reference Guide
- Training Video
- Prenatal Resource Directory
- Referral/Communication form
- Champions, specifically, the PPA Project Coordinator and the Family Violence Consultant who championed the Project in their respective jurisdictions of influence and were "the key to the Project's success". These are highly trained resource people who can deliver Project information.
- PEI service including the service provider experts, the service delivery infrastructure, and the established assessment, referral and intervention procedures. That is, the PPA Coordinator and the Family Violence Consultant created a service delivery system based on the integrated care model, which gradually became institutionalized. By visiting PEI, decision-makers from other jurisdictions can access and benefit from the PEI experience when considering PPA.

5.5 What would assist transfer of model and learnings to other situations?

The Advisory Committee Focus Group participants suggested that transferability of the PEI PPA Project could be enhanced as follows:

- Plan Ahead - "Think before you leap", or give considerable thought and planning before transferring the model to the new setting.
- Right Partners - Establish a broad support group composed of the "right partners" from the outset. This is inclusive of project champions: Coordinator, Advisory Committee, physicians, referral networks.

- Referral Network /Equivalents - If the referral network is not established, be sure to identify or establish equivalent supports/services before prenatal clients are assessed.

- Adapt Tool to Local Needs - Investigate adaptations of the PPA tools with the originators giving consideration to original ALPHA tools, PEI tools, and their regional/ provincial requirements.

- Training - Use learning packages as developed on PEI with only minor adaptation for geographic and service differences. Consider the number of trainers required in relation to the size of the recipient jurisdiction and the methods used to reach physicians and referral network providers for training.

- Interviewing Skills - Investigate and learn from the PEI physician experience in developing skills or techniques for interviewing.

- Physician Reimbursement - Negotiate the physician remuneration at the outset.

- Service Delivery Model - Consider differences in service delivery, e.g., the percent of obstetricians doing prenatal care and the availability of midwives.

- Staffing Levels - Consider the size of the province and planned method of implementation.

- Referral Patterns - When deciding referral possibilities consider travel distance and method of service delivery to ensure that it is practical for clients.

- Language - Consider the language and translation needs given the target population.

- Culture - Consider the cultural/ethnic adaptations required for the target population.

- Develop Guidebook - Develop a guidebook that encompasses all relevant applied experience to date, including the PEI experience with the PPA.

- Review PEI Resources - In the future transferability could be increased by reviewing existing relevant resources, e.g., papers from conferences, and any other resources that depict the PPA.

- Site Visit - Potential users from out-of-province could plan a visit to PEI so that first-hand experience could be gained with the philosophy, structure, and processes that accompany the PPA and hence a better match could be made between PEI and target site(s).

Dissemination Plan

Dissemination of the results of this initiative will be accomplished using a number of approaches. There will be in-province and out-of-province dissemination.

In-Province Dissemination:

The primary target audiences will include: Department of Health and Social Services directors and senior management, regional CEOs and senior management, family physicians, obstetricians, referral network personnel, The Medical Society of PEI, the College of Family Physicians, Transition House Association, the Premier's Action Committee on Family Violence, and Canada Prenatal Nutrition Programs, etc. Secondary target audiences will include: the Provincial Advisory Committee on the Status of Women, Women's Network, Early Childhood Education Association, and professional associations.

Methods of dissemination will include distribution of the final report and presentation of the results to these audiences. There will be an effort made to present the results at provincial conferences related to the subject areas. A presentation has been planned for the upcoming nurses' association conference and a presentation will also be made to the provincial Joint Perinatal Committee. As well, the Project Fact Sheet will be distributed in provincial and regional newsletters, including the Medical Society newsletter.

Out-of-Province Dissemination:

There will be a high degree of interest Nationally in the results of this project, as it will be the first provincial project of its kind. The final report will be distributed widely to a number of groups. These include: Canadian Perinatal Programs Coalition, provincial medical societies, College of Family Physicians of Canada, provincial Family Violence Coordinators, Victim Services contacts across Canada, five Women's Health Centres, Status of Women Canada, Human Resources Development Canada, Advisory Committee on Population Health, etc. An abstract has been accepted for presentation at the North American Primary Care Research Group Conference in Florida in November 2000. The ALPHA Pilot results and Project activities will be presented. Abstracts will continue to be submitted for presentations at conferences in and outside Canada. Specific conferences to be targeted include: SOGC, AWHONN Canada, Canadian Public Health Association, and IWK Grace. As well, articles will be written for publication in peer reviewed journals that pertain to the subject areas. Specific journals include: CMAJ, SOGCJ, JOGNN, CPHAJ, Canadian Journal of Nursing Research, and Canadian Family Physician. These dissemination activities will continue for a number of years following completion of the Project. The PEI Reproductive Care Program is committed to ensuring ongoing dissemination of this project.

Media Coverage:

When the Health Transition Fund projects were announced, a press conference was held and the PPA Project was described. This was picked up by local radio and was aired a number of times. As well, a newspaper article was written about the four provincial projects and is included in the Appendix L. As stated previously, an article was published in the Medical Society newsletter to inform the medical community about the project. A copy is also included in Appendix L.

Appendices

List of Appendices

Appendix A	Prenatal Psychosocial Assessment Tools	3
Appendix B	PEI Prenatal Psychosocial Assessment Model & Guidelines	4
Appendix C	Evaluation Plan	5
Appendix D	Evaluation Tools	17
	D1 Physician Pre-Education Survey	18
	D2 Physician Telephone Interview	20
	D3 Referral Network Mail Survey	26
	D4 Advisory Group Focus Group Discussion Guide	30
	D5 Project Staff Interview Guide	40
Appendix E	Data Summary: Physician Pre-Education Survey	47
Appendix F	Data Summary: Physician Telephone Interview	49
Appendix G	Data Summary: Referral Network Mail Survey	63
Appendix H	Data Summary: Advisory Committee Focus Group Discussion	71
Appendix I	Eight Dissemination Methods for ALPHA Pilot	89
Appendix J	Guidelines for Education of Physicians	91
Appendix K	Education Resource Package	93
Appendix L	Media Coverage	95

Appendix A

Prenatal Psychosocial Assessment Tools

PRENATAL PSYCHOSOCIAL HEALTH ASSESSMENT

Prenatal psychosocial problems may be associated with unfavorable postpartum outcomes. The questions on this form are suggested ways of inquiring about psychosocial health. Issues of high concern to the woman or caregiver usually indicate a need for additional supports or services. When issues of some concern are identified follow-up and/ or referral should be considered. Please consider the sensitivity of this information before sharing it with other caregivers.

Name:

PRENATAL FACTORS	COMMENTS/PLAN
MATERNAL FACTORS	
Prenatal care (late onset) (*WA*) • First prenatal visit in third trimester? (check records) • What is the reason that you did not start prenatal care sooner?	
Prenatal education (refusal or quit) (*CA*) • What are your plans for prenatal classes? • What is your reason for not attending/quitting prenatal classes?	
Feelings toward pregnancy after 20 weeks (*CA,WA*) • How did you feel when you first found out you were pregnant? • How do you feel about it now?	
Relationship with parents in childhood (*CA*) • How did you get along with your mother? Your father? • Did you feel loved by your mother? Your father?	
Self esteem (*CA*, WA) • What concerns do you have about becoming/being a mother? • What sort of mother do you think you'll be?	
History of psychiatric or emotional problems (*CA,WA*, PD) • Have you ever had emotional problems?How serious were they? • Have you ever seen a psychiatrist or counselor?	
Depression in this pregnancy (*PD*) • How has your mood been during this pregnancy? • Have you felt low or depressed during this pregnancy? • Were you depressed after previous pregnancies?	
FAMILY FACTORS	
Social support (*CA,WA*,PD) • How does your partner feel about your pregnancy? Your family? • Who will be helping you when you go home with your baby?	
Recent stressful life events (*CA,WA,PD*, PI) • What major life changes have you experienced this year? • What changes are you planning during this pregnancy? • How do you cope with stress in your life? Your partner? • Do you have any financial concerns or worries? *	
Couple's relationship (*CD,PD*, WA,CA) • How would you describe your relationship with your partner? • Has your relationship changed during your pregnancy? • What do you think your relationship will be like after the baby? • How will your partner be involved in looking after the baby?	

ASSOCIATED POSTPARTUM OUTCOMES

The prenatal factors in the left column have been shown to be associated with the postpartum outcomes listed below.
Bold, *Italics* indicates ***good*** evidence of association. Regular text indicates fair evidence of association.

CA - Child Abuse **CD** - Couple Dysfunction **PI**- Physical Illness **PD** - Postpartum Depression **WA** - Woman Abuse
LBW- Low Birth Weight

Adapted by PEI Reproductive Care Program with permission from ALPHA Project 1993, May 1998 version

*Questions added to original ALPHA.

PRENATAL FACTORS	COMMENTS/PLAN
SUBSTANCE USE **Tobacco/Alcohol/Drug Use (*WA*, *PI*, *LBW*, CA)** • Do you currently smoke cigarettes? If yes, how many cigarettes per day? Have you ever considered cutting down or quitting? * • Before you knew you were pregnant did you drink alcohol? * • Do you currently drink alcohol? If yes, how many drinks per week? Do you believe that you have a problem with alcohol? **C** Have you felt you ought to cut down your drinking? **A** Have people annoyed you by criticizing your drinking? **G** Have you felt bad or guilty about your drinking? **E** Have you ever needed an eye-opener in the morning to get going? • Before you knew you were pregnant did you use drugs?* (prescription/non-prescription/street drugs) • Do you currently use drugs? If yes, have you considered cutting down or quitting? Do you believe that you have a problem with drugs? • Does your partner use alcohol or drugs?	
FAMILY VIOLENCE **Woman or partner experienced or witnessed abuse (physical, emotional, sexual) (*CA*,WA)** • What was your parents' relationship like? • Did your father ever scare or hurt your mother? • Did your mother ever scare or hurt your father?* • Did either of your parents ever scare or hurt you? • Were you ever sexually abused as a child?	
Current or past woman abuse (*WA*,CA,PD) • How do you and your partner solve arguments? • Do you ever feel frightened by what your partner says or does? • Have you ever been hurt during a fight with your partner? • Has your partner ever humiliated you or emotionally abused you in other ways? • Have you ever been forced to have sex against your will?	
Previous child abuse by woman or partner (*CA*) • Do you have children not living with you? If so, for what reason? • Have you ever had involvement with Child & Family Services?	
Child discipline (*CA*) • How were you disciplined as a child? Were you ever spanked? • How do you think you will discipline your child? • How do you deal with your kids at home when they misbehave?	

How **concerned** are you about this woman's postpartum status? **Very** 1 2 3 4 5 **Not At All**

Follow-Up Plan:

- ☐ No Intervention Required
- ☐ Supportive Counseling by Physician
- ☐ Additional Prenatal Appointments
- ☐ Additional Postpartum Appointments
- ☐ Additional Well Baby Visits
- ☐ Public Health Nurse
- ☐ Prenatal Classes
- ☐ Community Nutritionist
- ☐ Community Mental Health
- ☐ Smoking Cessation Resource
- ☐ Addiction Services
- ☐ Parenting Classes/Support
- ☐ Family Resource Centre
- ☐ Psychiatrist
- ☐ Marital Counselor
- ☐ Anderson House
- ☐ Outreach Worker
- ☐ Child & Family Services
- ☐ Income Support
- ☐ Victim Services
- ☐ Legal Advice
- ☐ Self Help Clearing House
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Refused Referral

COMMENTS:

Date Completed _____

Signature _____

Ask Me! Identifying Stressors for Pregnant Women

Having a baby usually means changes in your family life. You may wish to discuss some of these changes with your doctor who may be able to help you. Please take a little time and answer the questions the best way you can.

Please answer the questions by making an "x" on the scale, writing an answer in the space, or marking "yes" or "no".
Your answers are confidential.

Your Own Life *Please answer the following questions about your own life and feelings.*

Prenatal Care

1. I first came for pregnancy care when I was _____ **months pregnant**

Prenatal Education

2. I am planning to take prenatal classes **No ___ Yes ____** If no, reason(s)_____

Feelings About Being Pregnant

3. My feelings about this pregnancy at first **very happy** |___|___|___|___|___|___| **very unhappy**
4. My feelings about this pregnancy now **very happy** |___|___|___|___|___|___| **very unhappy**

Further comments about these questions:

Relationship With Parents

5. I got along with my parent(s) when I was a child **very well** |___|___|___|___|___|___| **not at all**
6. As a child I felt loved by my mother **very much** |___|___|___|___|___|___| **not at all**
7. As a child I felt loved by my father **very much** |___|___|___|___|___|___| **not at all**

Further comments about these questions:

Feelings About Being a Mother

8. I have concerns about being a mother **none at all** |___|___|___|___|___|___| **very many**

Further comments about this question:

Emotional Health

9. I have/had emotional problems **No___Yes ___** If yes, describe_____
10. I have seen a psychiatrist/counselor **No___Yes ___** If yes, describe_____

Mood in This Pregnancy

11. In this pregnancy, my mood has usually been **very up** |___|___|___|___|___|___| **very down**

Further comments about these questions:

Your Family Life *Please answer the following questions about your family life.*

Emotional and Practical Support Available

12. About this pregnancy, my family feels **very happy** |___|___|___|___|___|___| **very unhappy**
13. About this pregnancy, my partner feels **very happy** |___|___|___|___|___|___| **very unhappy**
14. When I am home with the baby I will have help from (state relationship) _____

Further comments about these questions:

Recent Life Stresses (moving, job change or loss, family illness or death, financial concerns, and so on)

15. Over the past year, my life has been **very relaxed** |___|___|___|___|___|___| **very stressful**
16. I am making major changes during this pregnancy **No___Yes ___** If yes, describe_____

Further comments about these questions:

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Relationship With Partner (if this applies)

17. My partner and I get along — very well |__|__|__|__|__|__| not at all
18. After the baby, my partner and I will get along — very well |__|__|__|__|__|__| not at all

Further comments about these questions: _____

Substance Use *Please answer the following questions about use of tobacco, alcohol and other drugs in pregnancy*

19. I currently smoke cigarettes* — No___ Yes __ If yes, how many cigarettes per day?_____
If yes, I have cut down or considered quitting — No___ Yes __ If yes, describe_____
20. Before I knew I was pregnant I drank alcohol* — No___ Yes __ If yes, describe_____
21. I currently drink alcohol — No___ Yes __ If yes, how many drinks per week? _____ (1 drink = 1 1/2 oz liquor, 12 oz beer, 5 oz wine)
22. I believe I have a problem with alcohol — No___ Yes __ If yes, describe_____
23. Before I knew I was pregnant I used drugs* (prescription/non-prescription/street drugs) — No___ Yes __ If yes, describe_____
24. I currently use drugs — No___ Yes __ If yes, describe_____
25. I believe I have a problem with drugs — No___ Yes __ If yes, describe_____
26. My partner has drug/alcohol problems — No___ Yes __ If yes, describe_____

Further comments about these questions: _____

Family Violence *Please answer the following questions about violence in your family.*

Parents' Relationship (when you were a child)

27. My parents got along — very well |__|__|__|__|__|__| not at all
28. My father scared or hurt my mother — No___ Yes __ If yes, describe_____
29. My mother scared or hurt my father* — No___ Yes __ If yes, describe_____
30. My parent(s) scared or hurt me — No___ Yes __ If yes, describe_____

Further comments about these questions: _____

Relationship With Partner (if this applies)

31. We work out arguments with — no difficulty |__|__|__|__|__|__| great difficulty
32. Arguments with my partner scare me — never |__|__|__|__|__|__| always
33. I have been hurt during a fight with my partner — No___ Yes __ If yes, describe_____
34. My partner humiliates/emotionally abuses me — No___ Yes __ If yes, describe_____
35. My partner has forced me to have sex — No___ Yes __ If yes, describe_____

Further comments about these questions: _____

Children in the Family

36. I have children who are not living with me — No___ Yes __ If yes, describe_____

Child Discipline

37. I feel I was harshly disciplined by my parents — No___ Yes __ If yes, describe_____
38. I will discipline my child as my parents did — No___ Yes __ If yes, describe_____

Further comments about these questions: _____

* Added to original ALPHA form

Évaluation périnatale de l'état psychosocial

Nom :

s problèmes psychosociaux périnatals pourraient avoir des conséquences défavorables sur les ultats postnatals. Les questions ci-dessous se veulent un guide permettant d'évaluer l'état ychosocial de la patiente. Les questions les plus préoccupantes pour la femme ou le prestataire soins indiquent généralement un besoin de soutien ou de services additionnels. Lorsque des estions préoccupantes sont soulevées, il faut envisager de faire soit un suivi ou soit d'orienter la rsonne. Veuillez d'abord soupeser l'aspect de la sensibilité des renseignements avant de les mmuniquer à d'autres prestataires de soins.

Facteurs prénatals	Commentaires/plan d'action
acteurs maternels	
oins prénatals (première visite tardive) (VF) 1re visite au 3e trimestre? (vérifier dossier) Pourquoi n'avez-vous pas commencé vos consultations prénatales plus tôt?	
ducation prénatale (refus ou abandon) (EM) Prévoyez-vous suivre des cours prénatals? Pourquoi ne voulez-vous pas suivre/avez-vous abandonné les cours prénatals?	
entiments par rapport à la grossesse après 20 semaines (EM, VF) Comment avez-vous réagi quand vous avez su que vous étiez enceinte? Comment vous sentez-vous par rapport à votre grossesse aujourd'hui?	
elations avec les parents durant l'enfance (EM) Comment étaient vos relations avec votre mère? Avec votre père? Vous sentiez-vous aimée de votre mère? De votre père?	
stime de soi (EM, VF) Y a-t-il quelque chose qui vous préoccupe par rapport au fait que vous êtes mère/que vous allez être mère? À votre avis, quel genre de mère allez-vous être?	
ntécédents psychiatriques, troubles affectifs (EM, VF, DP) Avez-vous déjà souffert de troubles affectifs? Était-ce sérieux? Avez-vous déjà consulté un psychiatre ou un conseiller?	
épression en cours de grossesse (DP) Avez-vous des sautes d'humeur depuis que vous êtes enceinte? Vous êtes-vous sentie déprimée depuis que vous êtes enceinte? Lors de grossesses antérieures, avez-vous été déprimée après l'accouchement?	
Facteurs familiaux	
outien social (EM, VF, DP) Comment votre partenaire se sent-il par rapport à votre grossesse? Et votre famille? Qui vous aidera quand vous retournerez à la maison avec le bébé?	
vénements stressants récents (EM, VF, DP, M) Quels sont les changements majeurs qui sont survenus dans votre vie au cours de la dernière année? Quels sont les changements que vous prévoyez faire durant votre grossesse? Comment vous ajustez-vous au stress? Et votre partenaire? Avez-vous des inquiétudes ou des préoccupations d'ordre financier? *	
elation de couple (DC, DP, VF, EM) Comment décririez-vous vos relations avec votre partenaire? Est-ce que votre relation a changé depuis que vous êtes enceinte? À votre avis, quelle sera votre relation lorsque le bébé sera là? Comment votre partenaire prendra-t-il part aux soins du bébé?	

Résultats postnatals afférents

a été démontré qu'il existe un rapport entre les facteurs prénatals figurant dans la colonne de gauche et les résultats postnatals qui gurent ci-dessous. Les caractères gras indiquent un rapport évident. Les caractères romains indiquent un rapport moins évident.

M enfant maltraité **DC** difficultés dans le couple **M** maladie **DP** dépression du post-partum
F violence à l'égard de la femme **FPN** faible poids de naissance

apté par le Programme de soins périnatals de l'Î.-P.-É. avec l'autorisation du Projet ALPHA, mai 1998

* questions rajoutées par rapport au questionnaire d'origine

Facteurs prénatals	Commentaires/plan d'action
Alcool et autres drogues **Tabagisme/consommation d'alcool/de drogues (VF, M, FPN, EM)** • Fumez-vous? Combien de cigarette par jour? Avez-vous déjà songé à diminuer ou à arrêter?* • Consommiez-vous de l'alcool avant de savoir que vous étiez enceinte?* • Consommez-vous de l'alcool à l'heure actuelle? Combien de verres par semaine? Pensez-vous avoir un problème d'alcool? Sentez-vous que vous devriez diminuer votre consommation d'alcool? Vous a-t-on déjà ennuyée avec des remarques sur le fait que vous preniez de l'alcool? Vous êtes-vous sentie coupable ou mal par rapport au fait que vous preniez de l'alcool? Avez-vous déjà eu besoin d'un stimulant pour vous faire démarrer la journée? • Avant de savoir que vous étiez enceinte, consommiez-vous des drogues/médicaments?* (médicaments en vente libre/par ordonnance/drogues illicites) • Consommez-vous des drogues/médicaments à l'heure actuelle? Avez-vous déjà songé à diminuer ou à arrêter? Pensez-vous avoir un problème de drogues/médicaments? • Votre partenaire consomme-t-il de l'alcool ou des drogues/médicaments?	
Violence familiale **La femme ou le partenaire a été victime ou témoin de violence (physique, psychologique, sexuelle) (EM, VF)** • Comment était la relation entre vos parents? • Votre père a-t-il déjà effrayé ou blessé votre mère? • Votre mère a-t-elle déjà effrayé ou blessé votre père?* • Est-ce que l'un de vos parents vous a déjà effrayé ou blessé? • Avez-vous été agressée sexuellement étant enfant?	
Mauvais traitements par le passé ou à l'heure actuelle (VF, EM, DP) • Comment votre partenaire et vous réglez-vous vos différends? • Êtes-vous effrayée par ce que votre partenaire dit ou fait? • Avez-vous déjà été blessée lors d'une dispute avec votre partenaire? • Votre partenaire vous a-t-il déjà humiliée ou usé de violence psychologique avec vous? • Avez-vous déjà été forcée d'avoir des relations sexuelles contre votre gré?	
Mauvais traitements des enfants par l'un des partenaires (EM) • Avez-vous des enfants ne vivant pas avec vous? Pourquoi ne vivent-ils pas avec vous? • Avez-vous déjà eu à traiter avec les services à l'enfance et à la famille?	
Discipline des enfants (EM) • Comment avez-vous été disciplinée étant enfant? Avez-vous déjà eu la fessée? • À votre avis comment allez-vous discipliner votre enfant? • Que faites-vous lorsque vos enfants ne se comportent pas correctement à la maison?	

À quel point l'état postpartal de cette femme vous préoccupe-t-il? **énormément** 1 2 3 4 5 **aucunement**

Plan de suivi :

- ☐ Aucune intervention requise
- ☐ Counselling d'appui par le médecin
- ☐ Rendez-vous prénatals additionnels
- ☐ Rendez-vous postnatals additionnels
- ☐ Visites du bébé additionnelles
- ☐ Infirmière hygiéniste
- ☐ Cours prénatals
- ☐ Nutritionniste communautaire
- ☐ Santé mentale communautaire
- ☐ Ressources de lutte contre le tabagisme
- ☐ Services de toxicomanie
- ☐ Cours/appui sur le rôle parental
- ☐ Centre de ressources familiales
- ☐ Psychiatre
- ☐ Conseiller matrimonial
- ☐ Maison Anderson
- ☐ Travailleur des services d'approche
- ☐ Services à l'enfance et à la famille
- ☐ Soutien du revenu
- ☐ Service d'aide aux victimes
- ☐ Conseils juridiques
- ☐ Centre d'information d'entraide
- ☐ Autre _____
- ☐ Autre _____
- ☐ Autre _____
- ☐ A refusé d'être orientée ailleurs

Commentaires :

Date _____ **Signature** _____

Demandez-le-moi!
Identification de facteurs de stress chez les femmes enceintes

Le fait d'attendre un bébé signifie des changements en perspective dans votre vie. Vous pouvez discuter de certains de ces changements avec votre docteur qui peut être en mesure de vous aider. SVP prenez quelques instants pour répondre aux questions ci-dessous au meilleur de vos abilités.

Veuillez répondre aux questions en plaçant un « X » sur l'échelle, en inscrivant votre réponse dans l'espace prévu ou en répondant par oui ou par non, selon la question. Vos réponses demeureront strictement confidentielles.

Votre vie personnelle *(veuillez répondre aux questions ci-dessous qui traitent de votre vie et de vos sentiments)*

Éducation prénatale

1. Je suis venue consulter pour la première fois lorsque j'étais enceinte de _____ **mois**
2. J'ai l'intention de suivre des cours prénatals **Non** ___ **Oui** ___ Si vous n'en avez pas l'intention, indiquez pourquoi _____

Vos sentiments par rapport à la grossesse

3. Au début de ma grossesse, je me sentais... **très heureuse** |_|_|_|_|_|_| **très malheureuse**
4. Maintenant, par rapport à ma grossesse, je me sens **très heureuse** |_|_|_|_|_|_| **très malheureuse**

Avez-vous d'autres commentaires à ajouter à ce sujet?

Vos relations avec vos parents

5. Quand j'étais enfant, j'avais de bonnes relations avec mes parents **très bonnes** |_|_|_|_|_|_| **très mauvaises**
6. Quand j'étais enfant, je me sentais aimée de ma mère **beaucoup** |_|_|_|_|_|_| **pas du tout**
7. Quand j'étais enfant, je me sentais aimée de mon père **beaucoup** |_|_|_|_|_|_| **pas du tout**

Avez-vous d'autres commentaires à ajouter à ce sujet?

Vos sentiments par rapport à votre rôle de mère

8. Le fait de devenir mère me préoccupe **pas du tout** |_|_|_|_|_|_| **énormément**

Avez-vous d'autres commentaires à ajouter à ce sujet?

Votre santé affective

9. J'ai/j'ai eu des problèmes affectifs **Non** ___ **Oui** ___ Dans l'affirmative, précisez le genre _____
10. J'ai consulté un psychiatre/un conseiller **Non** ___ **Oui** ___ Dans l'affirmative, précisez _____

Votre moral durant cette grossesse

11. Durant cette grossesse, mon moral a été généralement **très bon** |_|_|_|_|_|_| **très mauvais**

Avez-vous d'autres commentaires à ajouter à ce sujet?

Votre vie familiale *(veuillez répondre aux questions ci-dessous qui traitent de votre vie et de vos sentiments)*

Soutien affectif et pratique à votre portée

12. Par rapport à ma grossesse, ma famille est **très heureuse** |_|_|_|_|_|_| **très malheureuse**
13. Par rapport à ma grossesse, mon partenaire est **très heureux** |_|_|_|_|_|_| **très malheureux**

Avez-vous d'autres commentaires à ajouter à ce sujet?

Facteurs récents de stress

15. Durant la dernière année, j'ai vécu mon quotidien de façon **très détendue** |_|_|_|_|_|_| **très tendue**
16. Je suis en train de faire des changements importants dans ma vie **Non** ___ **Oui** ___ Dans l'affirmative, précisez _____

Avez-vous d'autres commentaires à ajouter à ce sujet?

Adapté par le Programme de soins périnatals de l'Î.-P.-É. avec l'autorisation du Projet ALPHA, octobre 1996

Relations avec le partenaire (le cas échéant)

17. Mon partenaire et moi, nous nous entendons — très bien |_|_|_|_|_| très mal
18. Après l'arrivée du bébé, mon partenaire et moi allons nous entendre — très bien |_|_|_|_|_| très mal

Avez-vous d'autres commentaires à ajouter à ce sujet?

Usage d'alcool et d'autres drogues *(veuillez répondre aux questions ci-dessous qui traitent de tabagisme, de consommation d'alcool et d'autres drogues durant la grossesse)*

19. À l'heure actuelle, je fume la cigarette* Non ___ Oui ___ Dans l'affirmative, combien par jour? _____
Dans l'affirmative, avez-vous songé à réduire ou à cesser? Non ___ Oui ___ Dans l'affirmative, précisez _____

20. Avant de savoir que j'étais enceinte, je consommais de l'alcool* Non ___ Oui ___ Dans l'affirmative, précisez _____

21. Je consomme de l'alcool encore maintenant Non ___ Oui ___ Dans l'affirmative, précisez combien de verres par jour? ____

22. Je pense avoir un problème d'alcool Non ___ Oui ___ Dans l'affirmative, précisez _____

23. Avant de savoir que j'étais enceinte, je consommais des médicaments /des drogues (médicaments en vente libre, sur ordonnance, drogues illicites) Non ___ Oui ___ Dans l'affirmative, précisez _____

24. Je consomme des drogues/des médicaments à l'heure actuelle Non ___ Oui ___ Dans l'affirmative, précisez _____

25. Je pense avoir un problème de drogue/de médicaments Non ___ Oui ___ Dans l'affirmative, précisez _____

26. Mon partenaire a des problèmes de drogue/d'alcool/de médicaments Non ___ Oui ___ Dans l'affirmative, précisez _____

Avez-vous d'autres commentaires à ajouter à ce sujet?

Violence familiale *(veuillez répondre aux questions ci-dessous qui traitent de violence dans votre famille)*

Vos relations avec vos parents (étant enfant)

27. Mes parents s'entendaient bien — très bien |_|_|_|_|_|_| pas du tout
28. Mon père effrayait ou blessait ma mère Non ___ Oui ___ Dans l'affirmative, précisez _____

29. Ma mère effrayait ou blessait mon père* Non ___ Oui ___ Dans l'affirmative, précisez _____

30. Mes parents m'effrayaient ou me blessaient Non ___ Oui ___ Dans l'affirmative, précisez _____

Avez-vous d'autres commentaires à ajouter à ce sujet?

Votre relation avec votre partenaire (le cas échéant)

31. Nous réglons nos différends avec — beaucoup de facilité |_|_|_|_|_|_| beaucoup de difficulté
32. Quand j'ai un différend avec mon partenaire, cela m'effraie — jamais |_|_|_|_|_|_| toujours
33. J'ai déjà été blessée lors d'une dispute avec mon partenaire Non ___ Oui ___ Dans l'affirmative, précisez _____

34. Mon partenaire m'humilie/use de violence psychologique sur moi Non ___ Oui ___ Dans l'affirmative, précisez _____

35. Mon partenaire m'a forcée à avoir une relation sexuelle Non ___ Oui ___ Dans l'affirmative, précisez _____

Avez-vous d'autres commentaires à ajouter à ce sujet?

Les enfants

36. J'ai des enfants qui ne vivent pas avec moi Non ___ Oui ___ Dans l'affirmative, précisez _____

Les enfants et la discipline

37. J'ai le sentiment d'avoir été élevée très sévèrement par mes parents Non ___ Oui ___ Dans l'affirmative, précisez _____

38. Je vais discipliner mes enfants comme mes parents ont fait pour moi Non ___ Oui ___ Dans l'affirmative, précisez _____

Avez-vous d'autres commentaires à ajouter à ce sujet?

* Ces questions ont été rajoutées par rapport à la formule ALPHA d'origine

Prenatal Psychosocial Health Assessment

Referral / Communication Form

Name _____ Address _____

Phone (h) _____ (w) _____ Partner's Name _____ (if applicable)

Marital Status _____ Age _____ Due Date _____

Number of Pregnancies _____ Number of Children _____

Family Physician _____ Obstetrician _____

Referral To: _____

Has the woman agreed with and consented to this referral? Yes _____ No _____

Overall **level of concern** about this woman's prenatal status: **1** very concerned **2** **3** somewhat concerned

Reason for Referral/ Intervention Summary:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date _____ Signature _____

Print Name _____

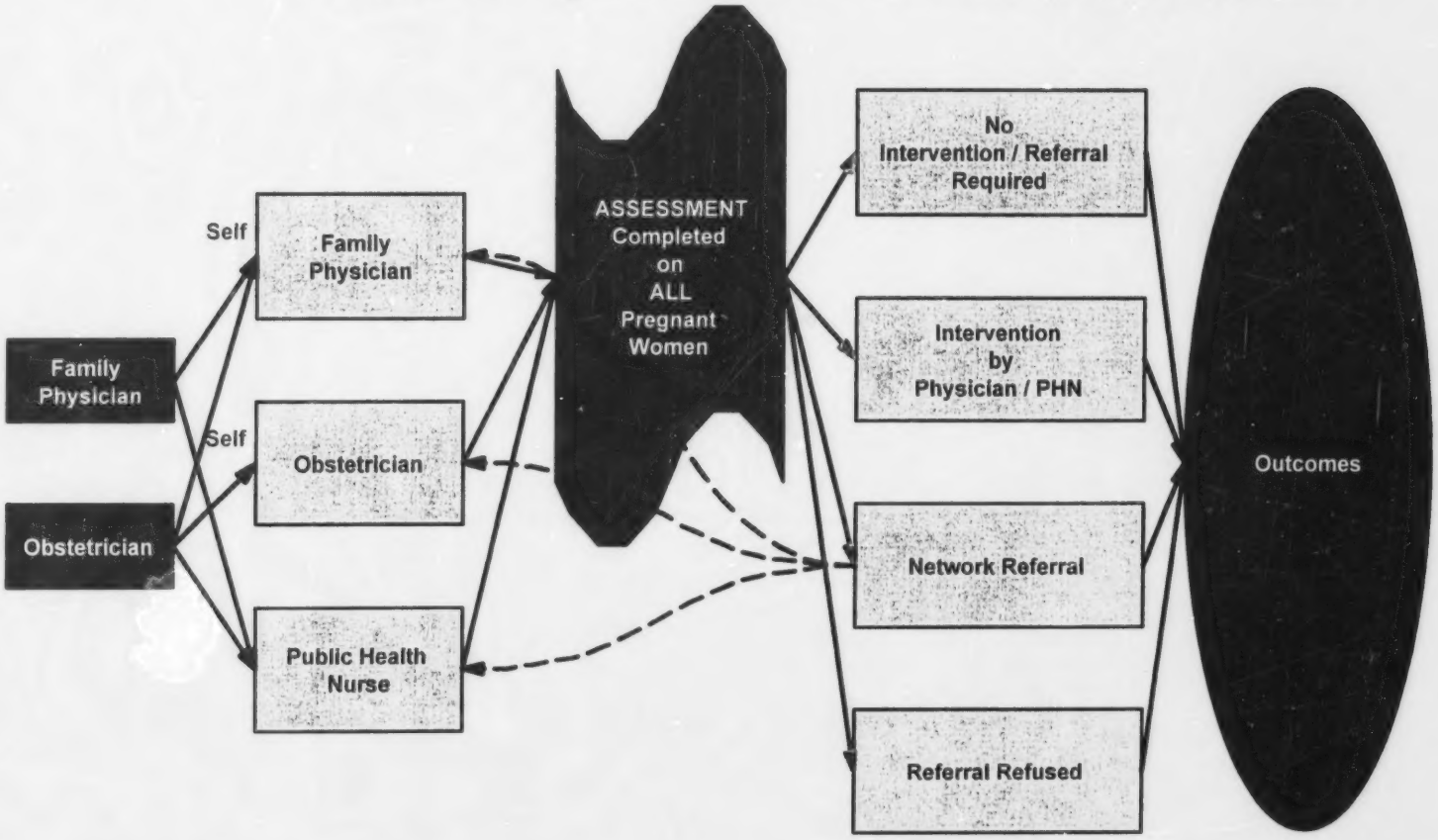
10-99

Copy 1 - Send this copy to Referral Agency

Appendix B

PEI Prenatal Psychosocial Assessment Model & Guidelines

Prenatal Psychosocial Assessment Model



Practitioners shown in grey boxes receive Education Program from Reproductive Care Program Coordinator.
Solid lines are program flow lines. Dashed lines are communication lines.

Prenatal Psychosocial Assessment
Guidelines

The following guidelines are recommended when using the Prenatal Psychosocial Assessment.

- The assessment will be completed on all pregnant women between 16-20 weeks gestation. Family physicians providing prenatal care during this time will complete the assessment. A 15 minute appointment should be booked.

- If a woman is receiving care from an obstetrician, she will be informed about the assessment and an appointment will be made with her family physician, who will complete the assessment. If the family physician is one who has not agreed to do the assessment or the woman does not have a family physician, the obstetrician has the option of completing the assessment or referring the woman to Public Health Nursing in her home region.

- The yellow self complete form will be given to the woman to complete in privacy. This form will help identify areas that require discussion. The green form will aid in discussion of areas of concern, documentation, and referral. Following the assessment, the green form becomes part of the woman's chart. The woman can keep the yellow form, destroy it, or choose to leave it on her chart.

- The Referral/Communication form will be used to make referrals to the appropriate agency and for communication between the family physician and obstetrician. The white copy goes to the agency and the yellow to the obstetrician/family physician (if applicable). The pink copy is to be kept on the woman's chart.

- This assessment has been approved to be billed as a separate visit. The billing code for family physicians and obstetricians is 2505 for up to 20 minutes and 2506 for 25 minutes or greater. Please use the V22 diagnostic code with this billing code.

- Please continue to document areas of concern on the woman's prenatal record.

- If you have questions or need replacement forms please call the PEI Reproductive Care Program office at 368-4952.

Appendix C

Evaluation Plan

Evaluation Plan

The evaluation of this project is based on the project's goals and objectives. It will include process and outcome variables. The Year 1 report will emphasize formative elements for improving the project and will primarily examine process issues. The Year 2 report will focus on summative evaluation of outcomes relating to effectiveness and health services utilization. Data collection methods will be qualitative and quantitative, and a triangulation of methods will be used to ensure dependability. A number of data collection instruments will be used to collect information from all groups participating in the project. A list of the data collection instruments and further details is found at the end of this section. The design for health status and health services utilization measures is a simple before and after design with elements of a time series designbuilt in for post-project monitoring and measurement.

It must be understood that evaluation of longer term health outcomes and most expected changes in health services utilization cannot be expected to occur within the two year time frame of this project. Only outcomes that are realistic in that time frame have been outlined. The objectives relating to resource utilization will require a number of years to assess but will eventually allow for reallocation of savings back into the system. It is clear that realization of this goal will only be beginning during the project. Along with the two formal evaluation reports outlined in this proposal, quarterly reports will be submitted to provide an update of the progress being made.

LOGIC MODEL

Philosophy	Structure/Process	Outcomes
An identification and integrated support process for all expectant mothers on PEI, and in particular, those with psychosocial needs.	Enhanced psychosocial assessment put in place for all expectant women with necessary training and supports. Development of an integrated response to mothers identified with psychosocial risks.	Increased identification of expectant mothers with psychosocial risk. Services delivered to expectant mothers in a more integrated manner. Improved maternal/ newborn health status. An estimation of the reduction in health service utilization by pregnant women and newborns in the long term.

Attribution

How will we know whether the outcomes we see are due to the project or other factors? A conclusive attribution of results using perfect controls is not possible. However, a number of approaches can be used to determine whether the outcomes seen were likely due to the project versus other factors.

First, the process of describing the program logic model can also be applied to analyses of results. Were changes actually made in service delivery that are sufficient in volume and strength to account for the kind of client outcomes that were seen? Have we chosen outcomes that could reasonably be expected to change based on the type of programmatic changes being made? Have there been changes in other programs or background variables that may have accounted for the outcomes? Second, was the timing of the change in outcomes such as we would expect if they were due to the project?

Primary Evaluation Questions

The five primary evaluation questions and their respective secondary questions are described below. These flow directly from the project goals and objectives as well as the evaluation requirements from Health Canada.

1. To what degree has the project enhanced prenatal psychosocial assessment for all expectant mothers on PEI?

2. To what degree has the project led to an appropriate and integrated response to identified psychosocial needs or risk factors?

3. How has this project impacted the health status of expectant/new mothers and their newborns?

4. What is the potential sustainability fo the integrated model of enhanced prenatal assessment and care?

5. In what ways would this project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?

Primary question # 1 To what degree has the project enhanced prenatal psychosocial assessment for all expectant mothers on PEI?			
Secondary evaluation question	**Indicator/Data**	**Source**	**Data Collection Method**
1.1 How were the results of the ALPHA pilot study disseminated, received, and supported by physicians and other health care providers?	- description of the dissemination process - perceptions re. the appropriateness of the dissemination process - perceptions re. how the results were received - perceptions re. the degree to which the results were supported	- Referral Network - Physicians - Project staff	- survey - interview - interview
1.2 What physicians were educated and how were they educated regarding the process of enhanced psycho-social assessment?	- description of the participants in the education process - description of the education process - perceptions of the education process	- Project staff	- interview
1.3 What educational material were used to educate physicians? (a) Were a reference guide and a referral network resource directory completed by Project staff? (b) Were they provided to physicians during the education process? (c) Were they considered useful?	- completed documents - report of receipt of documents by physicians - perceptions of usefulness (eg., completeness, organized, up to date, etc.)	- Documents - Physicians	- review - interview
1.4 What were the barriers and facilitators of implementing the enhanced psycho-social assessment?	- perceptions of barriers and facilitators (eg. to dissemination process, the education process, clinical factors, etc.)	- Referral network - Physicians - Project staff	- survey - interview - interview

Secondary evaluation question	Indicator/Data	Source	Data Collection Method
1.5 What was the physician knowledge/skill of, commitment to, comfort with, and level of satisfaction with performing the enhanced psycho-social assessment?	- perceptions re. knowledge/skills - perceptions re. commitment to process - perceptions re. comfort with process - perceptions re. satisfaction	- Physicians	- interview
1.6 Are physicians completing enhanced psychosocial assessment with all expectant women on PEI? If not, to what degree is this being done? What recommendations do they have to encourage completion of the enhanced psychosicial assessment with all expectant women on PEI?	- perceptions re. the degree to which it is being done / recorded - suggestions / recommendations	- Physicians	- interview

Primary question # 2 To what degree has the project led to an appropriate and integrated response to identified psychosocial needs or risk factors?			
Secondary evaluation question	**Indicator/Data**	**Source**	**Data Collection Method**
2.1 Was a model of integrated service delivery developed by Project staff? (a) What was this model? (b) What process was involved in its development?	- completed model - description of model - description of process	- Documents - Project staff	- review - interview
2.2 What are the barriers and facilitators of involving physicians and their referral network in an integrated model of service delivery?	- perceptions of barriers and facilitators	- Documents - Project staff - Physicians - Referral network	- review - interview - interview - survey
2.3 How have communication and intervention processes among the referral network changed as a result of enhanced psycho-social assessment and integration?	- perception of communication quality/amount between disciplines - awareness of roles of different disciplines - perception re. collaboration process - # referrals made - perception of appropriateness of referrals - perception of intervention quality	- Physicians - Service tracking system	- interview - survey - database
2.4 How has enhanced psychosocial assessment and integration affected client access to care?	- perception re. ease of access - timeliness of service	- Physicians - Service tracking system	- interview - survey - database
2.5 How has enhanced psycho-social assessment and integration affected duplication of services?	- perception re. duplication of services, i.e., does it exist? is it more or less?	- Physicians	- interview - survey

Secondary evaluation question	Indicator/Data	Source	Data Collection Method
2.6 What is the level of satisfaction of physicians and other members of referral networks with the integrated model of assessment and service delivery? Are additional training/supports required?	- physician/Referral network satisfaction - perceived training needs - other supports needed	- Physicians - Referral network	- interview - survey
2.7 What is the level of satisfaction of clients with the integrated model of assessment and service delivery?	- physician/referral network sense of clients' satisfaction with quality of the assessment; and the quality, timeliness, and coordination of the services and intervention(s) they receive.	- Physicians - Referral network	- interview - survey

Primary question # 3 How has this project impacted the health status of expectant/new mothers and their newborns?			
Secondary evaluation question	**Indicator/data**	**Source**	**Data Collection Method**
3.1 What health benefits for (a) expectant and new mothers, (b) their newborns, (c) and their families are perceived as a result of this project?	- perception of health benefits	- Physicians - Referral network	- interview - survey
3.2 What were the unintended health impacts of this project for (a) expectant and new mothers, (b) their newborns, (c) and their families?	- health and social status of expectant/new mothers and their newborns - increased public awareness of issues for expectant/new mothers and their newborns	- Physicians - Referral network	- interview - survey

Primary Question #4 What is the potential sustainability of the integrated model of enhanced prenatal assessment and care?			
Secondary evaluation question	**Indicator/data**	**Source**	**Data Collection Method**
4.1 What are the one time and sustainability costs of the project? (a) What is the one time cost associated with the development of the enhanced assessment and integrated service delivery model? (b) What are the predicted annual costs associated with sustaining this project?	- Project costs - Other associated costs	- Document - Project staff	- review - interview
4.2 What were the changes in resource utilization by expectant and new mothers and their newborns, and its associated cost to address psychosocial risk factors identified by the enhanced psychosocial assessment?	- services delivered (eg., # mental health admissions, # premature labour admissions, etc.), pre and post - hospital and family physician utilization - perceived reduction in duplication of services - perceived change in resources used	- Service tracking system - Medicare database - Physicians - Referral network	- database - database - interview - survey
4.3 What potential do enhanced psychosocial assessment and integration of services have for cost savings/containment?	- extrapolate literature / recent research studies to project - perceptions - how many years to achieve savings	- Documents - Project staff - Physicians - Referral network	- review - interview - interview - survey
4.4 All things considered, what is the rationale for continuing the enhanced psychosocial assessment and integrated service delivery model?	- perception of buy-in/ownership by physicians - satisfaction of clients - philosophy of health care - service universality - potential for future cost savings	- Physicians - Referral network - Project staff - Documents - Literature/Recent research studies	- interview - survey - interview - review - review

Primary Question #5 In what ways would this Project be transferable and/or generalizable to other regions/jurisdictions/programs/settings?			
Secondary evaluation question	**Indicator/data**	**Source**	**Data Collection Method**
5.1 How can new users of the model ensure successful adoption? (a) What system prerequisites were needed for the success of this project? (b) What obstacles to success were encountered? (c) How might they have been avoided?	- perceptions of system prerequisites - perceptions of the implementation process - perceptions of facilitators/barriers	- Steering Committee members	- focus group
5.2 Describe model transferability and generalizability. (a) What elements of this project seem particularly transferable to other regions/ jurisdictions/ programs/ settings? (b) How generalizable is the project?	- perceptions of transferability - perceptions of generalizability	- Steering Committee members	- focus group
5.3 What were the unintended effects/outcomes of this project? (a) Positive (b) Negative (c) Neutral	- improved health status of all women and their children - increased public awareness of issues for women's health - increased psychosocial assessment for women, children & families - improved knowledge and awareness of available services - improved integration of services for women, children & families	- Steering Committee members - Physicians - Referral network	- focus group - interview - survey

Secondary evaluation question	Indicator/data	Source	Data Collection Method
5.4 What resources were created that could be used to transfer learnings to other regions/jurisdictions/programs/settings?	- inventory stating item and potential user audience	- Documents - Steering Committee members	- review - focus group
5.5 What would assist transfer of model and learnings to other situations?	- list suggested resources	- Steering Committee members	- focus group

Appendix D

Evaluation Tools

D1	Physician Pre-Education Survey
D2	Physician Telephone Interview
D3	Referral Network Mail Survey
D4	Advisory Group Focus Group Discussion Guide
D5	Project Staff Interview Guide

Appendix D1

Evaluation Tools:
Physician Pre-Education Survey

PEI REPRODUCTIVE CARE PROGRAM

Physician Survey, Fall 1999 (Pre-Training Session)

The **ALPHA** (Antenatal Psychosocial Health Assessment) **Pilot Study** was completed in 1997 - 1998 by the PEI Reproductive Care Program. The purpose of the study was to explore the feasibility of enhancing psychosocial assessment for all pregnant women.

PART I:

a) Have you heard about the **ALPHA** Pilot Study? **Yes** □= **No** □=

b) If yes, how did you hear about it?

c) If yes, have you incorporated it into your practice? **Yes** □= **No** □=

PART II:

We are interested in your a) knowledge of, b) commitment to, c) comfort with, and d) support of prenatal psychosocial assessment. Please indicate your degree of agreement with the following statements: (SD = strongly disagree; D=Disagree; NAD=Neither agree nor disagree; A=Agree; and SA=Strongly Agree)

a) I am knowledgeable about how to perform prenatal psychosocial assessment.	**SD**	**D**	**NAD**	**A**	**SA**
b) I am committed to completing prenatal psychosocial assessment.	**SD**	**D**	**NAD**	**A**	**SA**
c) I am comfortable with performing prenatal psychosocial assessment.	**SD**	**D**	**NAD**	**A**	**SA**
d) I am supportive of prenatal psychosocial assessment.	**SD**	**D**	**NAD**	**A**	**SA**

PART III:

In your opinion, what are the potential barriers in PEI to completing prenatal psychosocial assessment with all pregnant women?

Thank You

Appendix D2

Evaluation Tools:
Physician Telephone Interview

Letter to Physicians

Doctor (Address)

September 7, 2000

Dear Dr. __

The Prenatal Psychosocial Assessment, coordinated by (Name of Project Co-ordinator), is funded by Health Canada's Health Transition Fund. The funding arrangement includes an evaluation of the project, and staff of the Evaluation Service have been contracted to carry out the evaluation for this initiative. As you may know, the focus of this assessment is to have a NEW Psychosocial Assessment completed by family physicians with ALL pregnant women on PEI. Information about the assessment has been provided by (Name of Educator).

We would appreciate it if you would agree to participate, in the interest of the prenatal psychosocial assessment in PEI, to help evaluate and improve the assessment process. We need to hear from you about:

1. your level of satisfaction with the preparatory information provided;
2. your implementation of the assessment into your practice; and
3. your perceptions of the impacts of the assessment.

The information you provide will be aggregated with information provided by other physicians and will be presented anonymously in any reports produced.

(Name), Research Assistant, will be contacting you within the next few weeks to schedule a telephone interview at your convenience.

Thank you, in advance, for agreeing to participate in the 10 minute telephone interview.

Sincerely,

Co-ordinator
Prenatal Psychosocial Assessment Initiative

Health Promotion Researcher
Evaluation Services

ID#_____

Enhancement of an Integrated Model of Prenatal Assessment and Care
Physician Interview

Introduction: My name is (Interviewer Name) and I am a research assistant with Evaluation Services. I am interviewing PEI physicians about the Prenatal Psychosocial Assessment Project that was presented to you by (Project Coordinator Name) with the Reproductive Care Program.

This interview will take approximately 10 minutes, and will be about:
1. your satisfaction with the information sessions;
2. how you have implemented the assessment into your practice; and
3. what impact the assessment has had.

Do you agree to have your interview for the evaluation of the Prenatal Psychosocial Assessment Project tape recorded, knowing that any information you provide will be kept secure and presented anonymously in any reports produced, yes or no?

☐ Yes
☐ No

Let's think back to the information meeting conducted by (Name).

1. Were you satisfied with the information meeting? Yes ☐ No ☐

   Comments:

2. Did the resources provided meet you needs? Yes ☐ No ☐

   Prompt: -the reference guide, the referral network resource directory, and the example video

   Comments:

Now that you have attended the information session and have had a chance to review or use the new assessment and referral forms...

3. (A) How many prenatal psychosocial assessments have you completed?

0	1-5	6-10	11-15	16-20	>20
☐	☐	☐	☐	☐	☐

(B) Is it your policy or do you plan to complete the prenatal psychosocial assessment with pregnant women in your practice? Yes ☐ No ☐

If not,

(C) What are your reasons for not completing or planning to complete the assessment with all pregnant women?

Please tell how much you agree with each of the following statements. Do you strongly agree, agree, disagree, strongly disagree, or are you neutral (neither agree nor disagree).

Statement	SA	A	N	D	SD
4. I have adequate knowledge to perform prenatal psychosocial assessment.	☐	☐	☐	☐	☐
5. I am committed to completing prenatal psychosocial assessment.	☐	☐	☐	☐	☐
6. I am comfortable with performing prenatal psychosocial assessment.	☐	☐	☐	☐	☐
7. I am supportive of prenatal psychosocial assessment.	☐	☐	☐	☐	☐

Has this project increased, decreased, or had no change on the following areas of practice ?

Area	Increased	Decreased	No Change
8. Your awareness of the various roles of service providers?	☐	☐	☐
9. The number of referrals you have made?	☐	☐	☐
10. The frequency of communication between you and other service providers?	☐	☐	☐
11. The quality of communication between you and your patients?	☐	☐	☐
12. The ease of patient access to services?	☐	☐	☐

<u>This page only if the respondent has completed one or more assessments</u>:

13. Have women refused referrals to services? Yes ☐ No ☐ N/A ☐

    <u>If yes</u>, for what reasons?

14. What type of interventions have you carried out with pregnant women as a result of this prenatal psychosocial assessment?

15. In your opinion, how has this assessment affected the health and well-being of:

    (A) expectant and new mothers?

    (B) newborns?

    (C) families?

    (D) others?

    Prompts:
    - *improved health status of all women and their children*
    - *increased public awareness of issues for women's health*
    - *increased psychosocial assessment for women, children and families*
    - *increased knowledge/awareness of available services*
    - *improved integration of services for women, children, and families*
    - *improved reporting*

As with any new initiative, there may be facilitators and barriers to the initiative.

16. What was it like to apply the assessment into your practice? What difficulties did you have and what made it easier?

17. In your opinion, are patients satisfied with the assessment? Yes ☐ No ☐ DK ☐

Please explain:

For all respondents:

18. Are you satisfied with the new psychosocial assessment? Yes ☐ No ☐

Please explain:

19. Are you satisfied with the new referral process? Yes ☐ No ☐

Please explain:

20. Do you feel the assessment should be continued? Yes ☐ No ☐

If yes:
For what reasons?

If no:
For what reasons?

21. Do you have any further comments regarding the prenatal psychosocial assessment?

Thank you for participating in this interview.

Appendix D3

Evaluation Tools:
Referral Network Mail Survey

Prenatal Psychosocial Assessment: Referral Network Questionnaire

Instructions:
For the following questions, please place an "x" in the appropriate ☐ to indicate your response (☒).

"Referrals" may include those for pregnant women or their significant other(s).

Some questions may require you to write in the space provided. Please feel free to write on the back of each page or to attach additional pages if necessary.

GENERAL INFORMATION: Please, tell us something about yourself:

1. In which health region do you work?

West Prince	East Prince	Queens	Southern Kings	Eastern Kings
☐	☐	☐	☐	☐

2. For which service agency/sector do you work? (e.g., Pubic Health Nursing, Community Nutrition, Outreach, etc.) _____

3. Has your agency had referrals as a result of the NEW Prenatal Psychosocial Assessment?

Yes	No	
☐	☐	***If no, do not continue. Thank you for your time.***

4. Approximately how many referrals has your agency received as a result of the Prenatal Psychosocial Assessment? #_____

5. Since implementing the Prenatal Psychosocial Assessment, how has the number of referrals **received** by your agency changed as a result of using the Prenatal Psychosocial Assessment?

Much Less	Somewhat Less	No Change	Somewhat More	Much More	Don't Know
☐	☐	☐	☐	☐	☐

6. Since the implementation of the Prenatal Psychosocial Assessment, how has the number of referrals **made** by your agency changed as a result of using the Prenatal Psychosocial Assessment?

Much Less	Somewhat Less	No Change	Somewhat More	Much More	Don't Know
☐	☐	☐ ☐	☐	☐	☐

7. To which services has your agency made referrals? (Please list)

_____
_____
_____
_____
_____

POTENTIAL CHANGES

For each area of potential change below, please indicate the best description of the change you see as a result of the assessment process: (Check one)

Area of Potential Change	Much Better	Somewhat Better	No Chang	Somewhat Worse	Much Worse	Don't Know
8. Frequency of communication between service providers.	☐	☐	☐	☐	☐	☐
9. Appropriateness of referrals received.	☐	☐	☐	☐	☐	☐
10. Length of waiting list for the service.	☐	☐	☐	☐	☐	☐
11. Other_____	☐	☐	☐	☐	☐	☐

12. Have these changes required new resources for your agency? Yes ☐ No ☐

If yes, please describe.

13. Has participating in this assessment/referrals had any financial impacts for clients? Yes ☐ No ☐

If yes, please describe :

14. In your opinion, how has this assessment affected the health and well-being of:

a) expectant and new mothers?

b) their newborns?

c) their families?

15. In your opinion, what has been the greatest benefit of the Prenatal Psychosocial Assessment?

16. How satisfied are you with this NEW assessment? (Check one)

Very Satisfied	Somewhat Satisfied	Neither dissatisfied nor Satisfied	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

Please explain:

17. How satisfied are you with this NEW referral process? (Check one)

Very Satisfied	Somewhat Satisfied	Neither dissatisfied nor Satisfied	Somewhat Dissatisfied	Very Dissatisfied
☐	☐	☐	☐	☐

Please explain:

18. Do you feel that the prenatal psychosocial assessment should continue? Yes ☐ No ☐

Please explain :

There may be facilitators and barriers to a NEW initiative. If another province or region was to take on an assessment like this one, what advice could your agency provide?

19. (A) What helped your agency incorporate the NEW referral process and the referrals resulting from this assessment?

(B) What made it difficult for your agency to incorporate the NEW referral process and the referrals resulting from this assessment?

(C) What further advice would you give to another province or region considering the adoption of the Prenatal Psychosocial Assessment?

20. Additional comments are welcomed. Please write in the space below or on the back of this page.

THANKS VERY MUCH FOR COMPLETING THIS QUESTIONNAIRE.
PLEASE RETURN IT IN THE ENVELOPE SUPPLIED BY SEPTEMBER ____TH, 2000.

Appendix D4

Evaluation Tools:
Advisory Group Focus Group
Discussion Guide

1. What System prerequisites were needed for the success of the Project?	
Category	**Pre-requisite**
People	
Funding	
Facilities	
Communication	
Procedures	
Context	
Other	

2. What are the project elements?

#	Elements	Sub-elements
1	Model	Integrated Service Delivery
2	Remuneration	Physician fee code
3	Assessment Tools	Ask Me! Identifying Stressors in Pregnant Women (Client Form)
		Prenatal Psychosocial Health Assessment Form (Physician Form)
4	Physician / Public Health Nurse Education	Small group/1:1 education sessions agenda /materials
		Alpha Pilot Report
		Demonstration Video
		Prenatal Psychosocial Health Assessment Reference Guide
		Prenatal Resource Directory
5	Referral Process	Referral/Communication Form Developed
		Referral Network information sessions agenda and materials
		Prenatal Resource Directory
6	Final Report	HTF Report
		Other dissemination
7	Other	

2a. Are there any other project elements?

2b. Are there any "Other suggestions" for the dissemination of the final report ?

3. What were the facilitators and the barriers of the Project?
1. Facilitators?
2. Barriers
3. How were the barriers managed?
4. How might these barriers have been avoided?

4. What were the expected outcomes / achievements from the Project?

#	Expected outcomes / achievements from PPA	Positive/Negative/ Neutral?		
		Pregnant woman	Service Provider	Families
1	Physicians have more knowledge/ awareness of PPA			
2	Physicians are more comfortable with PPA.			
3	Physicians are more committed to PPA.			
4	Physicians are more skilled in performing PPA.			
5	Physicians are completing PPA with all pregnant women.			
6	Prenatal records are more complete.			
7	Referral networks have been established in each health region.			
8	More interventions/referrals made for psychosocial issues of pregnant women.			
9	More collaboration within the prenatal care delivery system.			
10	Less duplication of services within the prenatal care delivery system.			
11	More timely response to the psychosocial needs of pregnant women.			
12	Improved quality of intervention/service for pregnant women.			
13	Improved health of Island mothers and their infants.			
14				
15				

4a. Were <u>all</u> of these items <u>intentional</u> outcomes or achievements? Yes/No?

4b. Were there <u>other</u> <u>intentional</u> outcomes or achievements?

4c. Were there any unintnetional / unexpected outcomes or achievements?

#	Unexpected outcomes / achievements	Positive/Negative/Neutral		
		Pregnant woman	Service Provider	Families
1				
2				
3				
4				
5				

5. Are the elements of this project transferable to other regions and provinces?

(See Q2 Responses)

	Transferable / usable elements		Y/N?	How	Users
1	Model of Integrated Service Delivery				
2	Remuneration				
3	Assess-ment Tools	.1 Ask Me! Identifying Stressors in Pregnant Women (Client Form)			
		.2 Prenatal Psychosocial Health Assessment form (Physician Form)			
4	Physician / PHN Education Program	.1 Small group/1:1 education sessions agenda /materials			
		.2 Alpha Pilot Report			
		.3 Demonstration Video			
		.4 Prenatal Psychosocial Health Assessment Reference Guide			
		.5 Prenatal Resource Directory			
5	Referral Process	.1 Referral/Communication Form Developed			
		.2 Referral Network information sessions agenda and materials			
		.3 Prenatal Resource Directory			
6	Final Report	.1 HTF Report			
		.2 Other forms of dissemination			

5. *Are the elements of this project transferable to other regions and provinces? Cont'd*

5.1 Are the other regions or provinces the same as the PEI situation in terms of psychosocial assessment of pregnant women? Would the project work the same in those regions or provinces? Explain.

5.2 What elements of this project are particularly transferrable to / usable by other regions or provinces? Check boxes.

5.3 What resources were created that could be used to transfer the model or learnings to other regions or provinces?

5.4 Who are the potential users of this information?

- ***Service providers?***
- ***Managers?***
- ***Policy makers?***
- ***Systems?***

5.5 What further recommendations or advice would you have with regard to the transferability of this project

6. Are the outcomes or achievements generalizable?

#	Outcomes or achievements	Generalizable?	
		Yes	No
1	Physicians have more knowledge/ awareness of PA.		
2	Physicians are more comfortable with PA.		
3	Physicians are more committed to PA.		
4	Physicians are more skilled in performing PA.		
5	Physicians are completing PA with all pregnant women.		
6	Prenatal records are more complete.		
7	Referral networks have been established in each health region.		
8	More interventions/referrals made for psychosocial issues of pregnant women.		
9	More collaboration within the prenatal care delivery system.		
10	Less duplication of services within the prenatal care delivery system.		
11	More timely response to the psychosocial needs of pregnant women.		
12	Improved quality of intervention/service for pregnant women.		
13	Improved health of island mothers and their infants.		
14			
15			

Appendix D5

Evaluation Tools:
Staff Interview Guide

ENHANCEMENT OF AN INTEGRATED MODEL OF PRENATAL ASSESSMENT AND CARE

PROJECT STAFF: INITIAL INTERVIEW

Contact: *Research Officer*
Public Health and Evaluation Division
Department of Health and Social Services

INTRODUCTION

As explained when the interview was scheduled _____ we would like to tape record and transcribe this interview. This tape will be locked up and only project research staff will have access to it. It will be destroyed after completion of the evaluation. You will not be referred to by name in any reports produced. The interview will take approximately 30 minutes.

The questions I will be asking you are about the dissemination process for the ALPHA Pilot Project and the response of involved groups to the information gained from this project. I will also be asking you about the "Enhancement of an Integrated Model of Prenatal Assessment and Care" project in terms of the process involved in developing the model, the actual model developed, the progress made with regards to the physician education component of this project, the present level of involvement of physicians and referral networks in an integrated model of service delivery. Finally, I would like to ask you a few initial questions with regard to the costs associated with this project.

You may stop the interview at any time. You can refuse to answer any question(s) if you prefer not to answer.

Would you consent to be interviewed as part of the evaluation of the Enhancement of an Integrated Model of Prenatal Assessment and Care and for this interview to be taped on the condition that you will not be referred to by name in any reports produced.

_____ _____

Respondent Signature *Date*

INTERVIEW SCHEDULE

I would like to start by asking you about the ALPHA Pilot Project. First, I would like to ask about the process used to disseminate the results of this study, specifically:

1. ***What individuals or groups were the focus of the dissemination process?***
   Prompt: ***- physician groups***
   - referral network
   - clients
   - committees/organizations

2. ***What tools/instruments/resources were used to disseminate the results of the ALPHA Pilot Project? List.***
   Prompt: ***- publications/releases***
   - media events
   - mailed information packages
   - meetings/presentations

3. ***What feedback did you receive with regards to the dissemination process from the involved groups? (groups from Part A) Forms of feedback and message.***
   Prompt: ***- written vs. verbal***
   - first hand vs. rumour
   - positive vs. negative
   - suggestions for improvement

4. ***Do you feel the dissemination process was appropriate for all interested/involved parties? (groups listed in question #1)***
   Prompt: ***- access to written materials***
   - access to presentations
   - advertising focus/invitation process/awareness
   - distribution process for written materials
   - level of technical vs. user friendly information
   - information was what you wanted to know

5. ***(A) What were the barriers to this process?***
   Prompt: ***- lack of access to interested/involved group(s)***
   - time constraints/priorities/competing agendas
   - resource/financial constraints
   - information not what you needed/wanted
   - buy-in/beliefs in need/efficacy
   - poor communication

(B) What were the facilitators to this process?

Prompt:
- *access to interested/involved group(s)*
- *timeliness/identified priority*
- *resources/finances available*
- *interesting/useful information*
- *belief in need*
- *good communication*

6. *How were results received by the interested/involved groups?*

Prompt:
- *with interest/indifference/disinterest*
- *positive/negative*

7. *How were results supported by the interested/involved groups?*

Prompt:
- *perception of credibility given*
- *interest in using results in practice*
- *requests for further information*

I would like to move on to talk about the project you are presently engaged in - the "Enhancement of an Integrated Model of Prenatal Assessment and Care" project.

I would like to start by asking you about the Model of Integrated Service Delivery you are using.

8. *(A) Please describe the Model of Integrated Service Delivery you developed?*

Prompt:
- *philosophy/context*
- *structure*
- *definition*
- *comparison to 'best practice' model*
- *outcomes sought*

(B) How did you develop this model? i.e., what was the process/what were the sources of input/influence that shaped the model which you developed?

Prompt:
- *establishment of need*
- *literature/influence*
- *collaborators/collaboration*
- *pretest/pilot*

I understand another project activity you have completed is the "Physician Education" component of this project.

9. (A) *What group(s) of physicians were targeted for the education component of this project?*

Prompt:
- *specialty: practice focus/involvement*
- *region of practice*
- *clinical history*

How many physicians from each group (a) were targeted and (b) actually completed the education component of this project?

(B) *Were physician group(s) included in the education component of this project who were not originally targeted? If so, who and why?*

Prompt:
- *by request*
- *specialty: practice focus/involvement*
- *region of practice*
- *clinical history*

How many physicians from each non-targeted group completed the education component of this project?

10. *What did the physician education component of this project involve?*

Prompt:
- *format (presentation, topic, speakers, discussion, small vs. large group, etc.)*
- *number and duration of session(s)*
- *education materials (handouts, literature, references, etc.)*
- *reference materials provided*

11. *What were the barriers and facilitators to the education process?*

(a) identification of involved group(s) _____
(b) access to involved group(s) _____
(b) time available _____
(c) resource/finances _____
(d) timeliness _____
(e) interest _____
(f) buy-in/beliefs in efficacy _____
(g) communication _____
(h) perception of need for training _____
(l) perception of # of clients in need _____
(j) other _____ _____

12. *To date,*

    (A) Who are the members of the referral networks?

    (B) How do the referral networks operate?

    (C) How are physicians and referral networks involved in the integrated model of service delivery?

13. *To date,*

    (A) What are the barriers and facilitators to the involvement of physicians and referral networks in an integrated model of service delivery?

    (B) How can these barriers be overcome?

    (C) What are the potential barriers and facilitators to the involvement of physicians and referral networks in an integrated model of service delivery?

    (D) How do you plan to circumvent or overcome these potential barriers?

Finally, I would like to ask you a few initial questions with regard to the costs associated with this project.

14. *(A) What is the one time cost associated with the development of the enhanced assessment and integrated service delivery model? i.e., start up costs*

    Prompt: - project costs
    - associated costs

    (B) What are the predicted annual costs associated with sustaining this project?

    Prompt: - project costs
    - associated costs

That completes the prepared questions.

15. ***Do you have any further comments, questions, or information you wish to share?***

We appreciate you taking the time to answer these questions.

Thank you for your involvement

Appendix E

Data Summary: Physician Pre-Education Survey

Physician Pre-Education Session Survey (n=46)

The **ALPHA** (Antenatal Psychosocial Health Assessment) **Pilot Study** was completed in 1997-1998 by the PEI Reproductive Care Program. The purpose of the study was to explore the feasibility of enhancing psychosocial assessment for all pregnant women.

PART I:

a) Have you heard about the **ALPHA** Pilot Study?

Yes=	34
No=	11
Missing=	01

b) If yes, how did you hear about it?

c) If yes, have you incorporated it into your practice?

Yes=	2
No=	30
N/A=	12
Missing=	2

PART II:

We are interested in your a) knowledge of, b) commitment to, c) comfort with, and d) support of prenatal psychosocial assessment. Please indicate your degree of agreement with the following statements: (SD=strongly disagree; D=Disagree; NAD=Neither Agree nor Disagree; A=Agree; and SA =Strongly Agree).

	SD	D	NAD	A	SA	Missing
a) I am knowledgeable about how to perform prenatal psychosocial assessment.	6	14	9	13	3	1
b) I am committed to completing prenatal psychosocial assessment.	0	4	15	21	4	2
c) I am comfortable with Performing prenatal Psychosocial assessment	3	8	9	22	3	1
d) I am supportive of prenatal Psychosocial assessment.	1	0	6	21	18	0

PART III:

In your opinion, what are the potential barriers in PEI to completing prenatal psychosocial assessment with all pregnant women?

Thank You.

Appendix F

Data Summary:
Physician Telephone Interview

Table of Contents

Letter of Introduction to Physicians		51
Structured Physician Telephone Interview		52
Question 1	Were you satisfied with the information meetings?	53
Question 2	Did the resources provided meet you needs?	53
Question 3a	How many prenatal psychosocial assessments have you completed?	54
Question 3b.	Is it your policy or do you plan to complete the prenatal psychosocial assessment with pregnant women in your practice?	54
Question 3c	If not, what are your reasons for not completing or planning to complete the assessment with all pregnant women?	55
Question 4	I have adequate knowledge to perform prenatal psychosocial assessment.	56
Question 5	I am committed to completing prenatal psychosocial assessment.	56
Question 6	I am comfortable with performing prenatal psychosocial assessment	56
Question 7	I am supportive of prenatal psychosocial assessment.	56
Questions 8-12	Has this project increased, decreased, or had no change on the following areas of practice?	57
Question 8.	Your awareness of the various roles of service providers?	57
Question 9	The number of referrals that you have made?	57
Question 10	The frequency of communication between you and your patients	57
Question 11	The quality of communication between you and your patients	57
Question 12	The ease of access to service areas.	57
Question 13	Have women refused referrals for service?	58
Question 14	What type if interventions have you carried out with pregnant women as a result of prenatal psychosocial assessment?	58
Question 15	In your opinion, has this assessment affected the health and well-being of expectant and new mothers, newborns, families, and others	59
Question 16	What was it like to apply the assessment into your practice? What difficulties did you have and what made it easier?	59
Question 17	In your opinion, are patients satisfied with the assessment?	59
Question 18	Are you satisfied with the new psychosocial assessment?	60
Question 19	Are you satisfied with the new referral process?	61
Question 20	Do you feel that the assessment should be continued?	61
Question 21	Do you have any further comments regarding the prenatal psychosocial assessment?	62

Letter of Introduction to Physicians

Physician Name
Physician Address

Date

Dear _____,

The Prenatal Psychosocial Assessment, coordinated by (Name), is funded by Health Canada's Health Transition Fund. As you may know, the focus of this assessment is having a NEW Psychosocial Assessment completed by family physicians with ALL pregnant women on PEI. Information about the assessment has been provided by (Name).

We would appreciate your agreement to participate in a 10 minute telephone interview to help evaluate and improve the assessment process. We need to hear from you about:

1. your level of satisfaction with the prepartory information provided;
2. your implementation of the assessment into your practice; and
3. your perceptions of the impacts of the assessment.

In the interests both of saving time and ensuring accuracy, we would like to tape record this interview with our assurance to you that the tapes will be accessed by Evaluation Services staff only, and will be kept secure until destroyed. The information you provide will be presented anonymously in any reports produced. We will not, of course, record the interview without your permission to do so.

We will be contacting you within the next few weeks to schedule an interview at your convenience.

Thank you, in advance, for agreeing to participate in the 10 minute telephone interview.

Sincerely,

_____

Project Coordinator
Health Promotion Researcher
PEI Reproductive Care Program
Evaluation Services

Structured Physician Telephone Interview

Enhancement of an Integrated Model of Prenatal Assessment and Care
Physician Interview (ID#_____)

Introduction: My name is (Name of Health Researcher-Interviewer) and I am a research assistant with Evaluation Services. I am interviewing PEI physicians about the Prenatal Psychosocial Assessment Project that was presented to you by (Project Coordinator) with the Reproductive Care Program.

This interview will take approximately 10 minutes, and will be about:

1. Your satisfaction with the information sessions;
2. How you feel about the prenatal psychosocial assessment; and
3. If you plan to implement this assessment into your practice.

As explained in the letter, I would like to tape record this interview. The tapes will be accessed by evaluation services staff only and will be kept secure until destroyed. The information you provide will be presented anonymously in any reports produced.

[Turn tape recorder on]

NOTE: *Because physicians received an informed letter in advance to the follow-up call for the interview, plans changed and these interviews were not tape recorded.*
Do you agree to have your interview for the evaluation of the Prenatal Psychosocial Assessment Project tape recorded, knowing that any information you provide will be kept secure and presented anonymously in any reports produced, yes or no?

- ☐ Yes
- ☐ No

Editorial Note: *This summary contains frequency and narrative summaries for the Telephone Survey which measured implementation experience of physicians (also included obstetricians and public health nurses). It was conducted in June and September of 2000 which was 1-3 months after project implementation and 1-9 months after the education sessions. The months are shown simply to separate the first implementation sites (West Prince and East Prince) from the more recent areas (Queens Region, and Eastern and Southern Kings).*

Summary Report - Physician Telephone Interview

1. Were you satisfied with the information meetings? (N=37)			
Group	**Yes**	**No**	**Total (n)**
MD - June '00	17	0	17
MD - Sept. '00	18	0	18
PHN - Sept. '00	1	1	2
TOTAL	36	1	37

Summary - All physicians (n=35) were satisfied with the training sessions whether conducted in small groups or on a one-to-one basis by the Project Coordinator. One Public Health Nurse (PHN) questioned whether they were being prepared to perform the prenatal psychosocial assessment (PPA), but not one physician complained that they were not prepared to conduct the PPA.

2. Did the resources provided meet you needs? **Prompt: Reference guide, the referral network resource directory, and the example video**				
Group (n)	**Yes**	**No**	**N/A**	**Total**
MD - June '00	17	0	0	17
MD - Sept. '00	16	0	2	18
PHN - Sept. '00	1	1	0	2
TOTAL	34	1	2	37

Summary - The majority of physicians (34/37) reported that the resources met their needs. This figure may be slightly underestimated since two physician respondents refrained from answering having not yet used the PPA. Only one person disagreed - a Public Health nurse who said the Training Session addressed the "Ask Me" issues but not other issues which PHN's know need to be addressed with the expectant mother. It must be noted however that this was not an intended outcome of this current initiative.

3a. How many prenatal psychosocial assessments have you completed?							
Group	Number of assessments completed						
	0	1 to 5	6 to 10	11 to 15	16-20	>20	Total (n)
MD - June '00	9	7	1	0	0	0	17
MD - Sept. '00	11	7	0	0	0	0	18
PHN - Sept. '00	0	2	0	0	0	0	2
TOTAL	20	16	1	0	0	0	37

Summary - Three months post-training the respondents were almost equally divided with 20 physicians having not yet performed a PPA and 17 physicians/PHNs having performed the PPA. Among the 17 users, 16 had used the PPA from 1-5 times. Only one person reported using the PPA more than five times, i.e. 6-10 time category. The number of PPAs completed was far less than expected due to the short time period between implementation and follow-up and hence the small number of prenatal clients that would have presented at physician offices. With approximately 1500 births per year divided by 12 months the total intake province-wide would be 125 per month, or about one per physician in the sampling frame.

3b. Is it your policy or do you plan to complete the prenatal psychosocial assessment with pregnant women in your practice?					
Group (n)	Number of Respondents				
	Yes	No	Neutral	N/A	Total
MD - June '00	14	2	1	0	17
MD - Sept. '00	13	3	0	2	18
PHN - Sept. '00	1	1	0	0	2
Total:	28	6	1	2	37

Summary - The majority, 28/37 respondents, already used or planned to use the PPA with pregnant women in their practice. Nine persons did not give a "Yes" answer. Judging from their later comments, it was because they had not yet tried the PPA and therefore they refrained from making any judgments regarding its' relevance and effectiveness in addressing psychosocial issues among this sector of the population.

3c. If not, what are your reasons for not completing or planning to complete the assessment with all pregnant women?

Summary - The 9 non-users cited deterrents which revolved around time and roles: 1) lack of time to do the PPA; 2) obstetricians wanting to refer patients back to family physicians or public health nurses for completion of the PPA (this had already been built into the model); 3) generalists wanting to refer the patient to the specialist for completion of the PPA; and 4) the opinion that the physician that follows the patient on the long-term, generalist or specialist, should do the PPA. Given the emphasis placed on time throughout the survey, it is possible that the role-related reasons may be at least partly time-related reasons if explored further.

Questions 4-7: Please tell how much you agree with each of the following statements. Do you strongly disagree (SD), disagree (D), agree (A), strongly agree (SA), or are you neutral (neither agree nor disagree, NAD).								
Statement	**Number of Respondents**							
	Group	**SA**	**A**	**N**	**D**	**SD**	**N/A**	**Total**
Q4. I have adequate knowledge to perform prenatal psychosocial assessment.	MD-June	4	9	1	2	0	1	17
	MD-Sept.	3	4	0	0	0	1	8
	PHN-Sept.	0	1	1	0	0	0	2
Q5. I am committed to completing prenatal psychosocial assessment.	MD-June	2	10	2	2	0	1	17
	MD-Sept.	1	12	1	2	1	1	18
	PHN-Sept.	0	2	0	0	0	0	2
Q6.I am comfortable with performing prenatal psychosocial assessment.	MD-June	3	11	0	2	0	1	17
	MD-Sept.	1	13	2	0	0	2	18
	PHN-Sept.	0	1	0	0	0	1	2
Q7.I am supportive of prenatal psychosocial assessment.	MD-June	5	8	3	0	0	1	17
	MD-Sept.	5	13	0	0	0	0	18
	PHN-Sept.	2	0	0	0	0	0	2
Total:	All	26	84	10	8	1	9	138
Grouped totals:	All	110		10	9		9	138

Summary - Overwhelmingly, the physicians have the knowledge, commitment, comfort level, and philosophical support to use the PPA. Some non-agreement was due to not yet having used the tool. Overall, the PPA was well supported in theory and practice.

Questions 8-12: Has this project increased, decreased, or had no change on the following areas of practice?

Area	Number of Respondents Citing Each Answer					
	Group	Increased	Decreased	No Change	N/A	Total
8. Your awareness of the various roles of service providers?	MD-June	7	0	9	1	17
	MD-Sept.	8	0	8	2	18
	PHN-Sept.	1	0	1	0	2
9. The number of referrals you have made?	MD-June	1	0	15	1	17
	MD-Sept.	3	0	12	3	18
	PHN-Sept.	0	0	2	0	2
10. The frequency of communication between you and your patients?	MD-June	3	0	12	2	17
	MD-Sept.	4	0	11	3	18
	PHN-Sept.	1	0	0	1	2
11. The quality of communication between you and your patients?	MD-June	5	0	10	2	17
	MD-Sept.	5	0	11	2	18
	PHN-Sept.	1	0	1	0	2
12. The ease of patient access to services?	MD-June	1	0	13	3	17
	MD-Sept.	1	0	12	5	18
	PHN-Sept.	1	0	1	0	2
Total:		42	0	118	25	185

Comments, Question #8 - your awareness of the roles of service providers

Summary - The majority of responses were "no change" (118/185) mainly due to the short time period and therefore the lack of opportunity to observe the outcomes from using the PPA among their prenatal clients. Almost one-fifth (42/185 responses) indicated an increase especially in the areas of 1) increased awareness about referral services, and 2) communication both with regard to the frequency and the quality of communication with their clients. It is very notable that no decreases were reported in any of the five indicators measured. Approximately 10% (25/185) of responses were "not applicable" due to their belief that the PPA did not apply to their practice for the four time and role related reasons which were stated above.

Ask only if the respondent has completed one or more assessments:

13. Have women refused referrals to services? If yes, for what reasons?				
Group	**Yes**	**No**	**N/A**	**Total**
MD-June	2	4	2	8
MD-Sept.	1	6	0	7
PHN-Sept.	2	0	0	2
Total:	5	10	2	17

Summary - Among women receiving a referral there was a 2:1 ratio of acceptors to refusers (10 vs. 5 women). Therefore, at this early stage of implementation the response among the target audience is positive. Some physicians indicated that the reasons for refusing were 1) not wanting to attend prenatal classes, 2) public health nurses already referring the woman to services such as nutrition which could be ascertained early in pregnancy, and 3) one woman who refused intervention and wanted to change physicians after being told that she should examine and change her illicit drug behaviour.

14. What type of interventions have you carried out with pregnant women as a result of this prenatal psychosocial assessment?

Summary - Interventions arising from use of the PPA to date included 1) nutrition counseling in two cases, 2) mental health and stress counseling in two cases, 3) smoking / cessation in two cases, 4) relationship issues in two cases, 5) breast-feeding in one case, and 6) promotion of healthy lifestyle in one case. Beyond general prenatal counseling one user noted that a confidential call was made to the obstetrician regarding a "delicate issue". While all reasons fit the range of health care issues to be addressed by the PPA it is very gratifying that the psychosocial issues such as mental health, stress, relationship, and the "delicate issues" could be addressed by implementation of the PPA.

15. In your opinion, how has this assessment affected the health and well-being of a) expectant and new mothers?, b) newborns, c) families, and d) others?

Prompts:

- improved health status of all women and their children
- increased public awareness of issues for women's health
- increased PPA of women, children, and families
- increased knowledge/awareness of available services
- improved integration of services for women, children, and families
- improved reporting

Summary - It was too early to say for sure. But, the process opened the door for better communication, and the information was useful in better understanding client situations.

16. What was it like to apply the assessment into your practice? What difficulties did you have and what made it easier?

Summary - Time to complete the PPA was the biggest barrier. Some doctors asked the woman to complete the form at home and bring it to the next appointment to save office time. Forgetting to book the time to complete the office assessment can occur during a busy schedule. Lastly, no-shows may be somewhat of a problem.

17. In your opinion, are patients satisfied with the assessment? Please explain.

Group	Yes	No	DK	N/A	Total
MD-June	6	1	0	1	8
MD-Sept.	6	0	1	0	7
PHN	2	0	0	0	2
Total:	14	1	1	1	17

Summary - Overwhelmingly, the vast majority of patients were satisfied with the assessment (14/17), according to the physicians who asked the PPA questions. The remaining three physicians may not have replied due to lack of experience using the PPA so that the figure may even be underestimated.

Ask this page of questions to all respondents.

18. Are you satisfied with the new psychosocial assessment? Yes, or No. Please explain.						
Group	**Number of Respondents**					
	Yes	**No**	**DK**	**Neutral**	**N/A**	**Total**
MD-June	14	0	0	3	0	17
MD-Sept.	14	0	0	0	4	18
PHN-Sept.	1	0	0	0	1	2
Total:	29	0	0	3	5	37

Summary - The majority of physicians/PHNs were satisfied with the new PPA (29/37), no one was dissatisfied, and almost one-quarter (8/37) were neutral or thought it not applicable to their medical practice probably due to not having used the PPA yet or thinking it should be referred to another professional for completion, e.g., physician, public health nurse, or multidisciplinary team member. The tool was described as holistic and multidisciplinary in approach. It was suggested that at least one doctor had already tried such an innovation on his / her own and was pleased to see it formalized. One respondent suggested that the PPA schedule be shortened if possible. Referring patients back appeared to be a part of the procedure which requires more attention as time, practice, and role-related issues are worked through. It was noted that some users viewed the PPA as a "guide" rather than a rigid interview or assessment schedule. Lastly, one respondent suggested that a general version of the form be developed for use with all patients. Overall, the comments were very constructive and supportive of the PPA. It appeared to be a tool whose time had come especially since it provided a more complete picture of the client with which the physician could work to improve the service offered to clients.

19. Are you satisfied with the new referral process? Please explain.						
Group	Number of Respondents					
	Yes	No	DK	Neutral	N/A	Total
MD-June	12	0	0	5	0	17
MD-Sept.	11	0	0	0	7	18
PHN-Sept.	0	0	0	0	2	2
Total:	23	0	0	5	9	37

Summary - More than one-half of the respondents (23/37) were satisfied with the streamlined referral process. The remainder (14/37) did not commit 1) having not used the PPA yet, and / or 2) thinking another person / role should complete the PPA.

20. Do you feel that the assessment should be continued? If yes, for what reasons? If no, for what reasons?						
Group	Number of Respondents					
	Yes	No	DK	Neutral	N/A	Total
MD-June	14	1	1	0	1	17
MD-Sept.	15	0	0	0	3	18
PHN-Sept.	2	0	0	0	0	2
Total:	31	1	1	0	4	37

Summary - Clearly, the majority of respondents, 31 of 37, thought that the PPA should be continued. Only one person dissented. The question was not applicable to five respondents due to their not having completed the PPA or not being the designated assessor. The need for psychosocial assessment was articulated and strongly supported by several respondents. The comments suggested that there is a learning curve as health care providers refine their skills in asking personal questions, but that the outcomes for client health and physician care make it a worthwhile venture. Additional training sessions were suggested by a few respondents. Overall, experience was limited but the potential for improved patient outcomes was obvious from the synthesis of comments.

21. Do you have any further comments regarding the prenatal psychosocial assessment?

Summary - The concluding voluntary comments reflected support for the PPA but concern for the 1) time, 2) correct assessor, 3) length, 4) introductory piece, 5) compensation, and 6) workload to assess all prenatal clients. Overall, the comments were supportive so these issues are just part of implementing a new program to the point where the processes or procedures are acceptable to all persons concerned.

Appendix G

Data Summary :
Referral Network Mail Survey

Prenatal Psychosocial Assessment: Referral Network Mail Survey

Instructions

For the following questions, please place an "x" in the appropriate ☐ to indicate your response (☒).

"Referrals" may include those for pregnant women or their significant other(s).

Some questions may require you to write in the space provided. Please feel free to write on the back of each page or to attach additional pages if necessary.

GENERAL INFORMATION:

Question 1. In which health region do you work?

West Prince	=5
East Prince	=4
Queens	=5
Southern Kings	=4
Eastern Kings	=2

Summary - Referral network providers across the Island were trained, however only a minority responded. Please note that staff from the Referral Network can work in one or up to 3 regions. In reference to the above totals this has occured on 4 occasions.

Question 2. For which service agency/sector do you work? (e.g., Pubic Health Nursing, Community Nutrition, Outreach, etc.)

Public Health Nursing	=3
Child Welfare	=3
Family Violence Prevention	=2
Addictions	=2
Office of Attorney General	=1
Transition House (Outreach)	=2
Psychologist	=1
Community Mental Health	=1
Community Nutrition	=1

Summary - At least twenty different service providers were included in the Referral Network. The most frequently used services are listed below.

- Supportive Counselling by self
- Additional prenatal appointments
- Additional postpartum appointments
- Additional well baby visits
- Public Health Nurse
- Prenatal Classes
- Community Nutritionist
- Family Resource Center
- Community Mental Health
- Parenting Classes / support group
- Addiction treatment program
- Smoking cessation resources
- Social worker
- Psychologist / psychiatrist
- Anderson House
- Child & Family Services
- Victim Services
- Outreach Workers
- Turning Point
- Legal advice
- Other (Specify)
- Refused Referral

Among the Referral Network only 9 providers replied to the survey, and they represented only seven service areas as follows: Public Health Nursing, Child Welfare, Family Violence Prevention, Addictions, Office of Attorney General, Transition House (Outreach), and Psychology. Among these 9 respondents one Public Health Nurse and one Family Violence Prevention specialist received referrals. Therefore, the actual volume and range of respondents was very low compared to the volume and range expected at the outset. This was due to the short implementation/evaluation time frame.

Question 3. Has your agency had referrals as a result of the NEW Prenatal Psychosocial Assessment?

Yes =2 No =7 *If no, <u>do not</u> continue. Thank you for your time.*

Summary - As noted above, only 2 of 9 referral network providers received referrals. One person expressed regret thinking that the enhanced PPA was a very valuable tool with potential to improve the quality of life for Islanders.

Question 4. Approximately how many referrals has your agency received as a result of the Prenatal Psychosocial Assessment? # = 2

Question 5. Since implementing the Prenatal Psychosocial Assessment, how has the number of referrals received by your agency changed as a result of using the Prenatal Psychosocial Assessment?

Much Less	=0
Somewhat Less	=0
No Change	=2
Somewhat More	=0
Much More	=0
Don't Know	=0

Summary - Providers observed "no change" in the volume of referrals to date. Possibly with time the number of referrals will increase.

Question 6. Since the implementation of the Prenatal Psychosocial Assessment, how has the number of referrals made by your agency changed as a result of using the Prenatal Psychosocial Assessment?

Much Less	=0
Somewhat Less	=0
No Change	=2
Somewhat More	=0
Much More	=0
Don't Know	=0

Summary - Just as the number of referrals received was unchanged so the number of referrals made was unchanged. This situation is unlikely to change until the number of referrals to providers increases.

Question 7. To which services has your agency made referrals? (Please list)

Summary - To date the child development / parenting program and nutrition programs were the only referrals. These are typically high use areas for prenatal clients.

POTENTIAL CHANGES

For each area of potential change below, please indicate the best description of the change you see as a result of the assessment process: (Check one)

Areas of Potential Change							
Question	Statement	Much Better	Somewhat Better	No Change	Somewhat Worse	Much Worse	Don't Know
8	Frequency of communication between service providers.		1				
9	Appropriateness of referrals received						1
10	Length of waiting list for the service.						1
11	Other						

Summary - One network service provider reported that the PPA increased the frequency of communication while no comments were made regarding other expected outcomes given the short period of implementation.

Question 12. Have these changes required new resources for your agency?

Yes =1 No =1
If yes, please describe.

Summary - Resource needs were increased in one case and decreased in the other case. With low referral rates and a low response rate it is difficult to form any conclusion or even trend for the future.

Question 13. Has participating in this assessment/referrals had any financial impacts for clients?

Yes =0 No =2 If yes, please describe :

Summary - For the referrals received there were no reported additional costs or financial hardship. However, the response to this question can vary with the level of awareness of the respondent, stage of intervention, and type of services involved plus other variables.

Question 14. In your opinion, how has this assessment affected the health and well-being of:

a) expectant and new mothers?

b) their newborns?

c) their families?

Summary - With regard to the impact of the PPA on health and well-being the response revolves around anticipated rather than actual benefit as the respondent reasoned that early identification should lead to early intervention and hence fewer problems.

Question 15. In your opinion, what has been the greatest benefit of the Prenatal Psychosocial Assessment?

Summary - It was predicted that the greatest benefit would be early identification of maternal problems.

Question 16. How satisfied are you with this NEW assessment? (Check one)

Very Satisfied	=1
Somewhat Satisfied	=0
Neither dissatisfied nor Dissatisfied	=0
Somewhat Dissatisfied	=0
Very Dissatisfied	=0
Don't Know	=1

Please explain:

Summary - Comments regarding the PPA were very positive, but more cases need to be tracked to be sure.

Question 17. How satisfied are you with this NEW referral process? (Check one)

Very Satisfied	=0
Somewhat Satisfied	=1
Neither dissatisfied nor Dissatisfied	=0
Somewhat Dissatisfied	=0
Very Dissatisfied	=0
Don't Know	=0
No Response	=1

Please explain:

Summary -The initial responses suggest a favorable level of satisfaction. More cases in number and type need to be tracked to truly answer this question in a reliable manner.

Question 18. Do you feel that the prenatal psychosocial assessment should continue?

Yes	=2
No	=0

Please explain :

Summary - The two respondents agreed that the PPA should continue thereby expressing satisfaction just as the physicians had expressed but in greater numbers and with more first-hand experience.

Question 19 (A) **What helped your agency incorporate the NEW referral process and the referrals resulting from this assessment?**

Summary - Organizational participation from the initial implementation onward was credited with acceptance of the PPA.

Question 19(B) **What made it difficult for your agency to incorporate the NEW referral process and the referrals resulting from this assessment?**

Summary - Again, small response pool limit statements that are conclusive or indicative of trends. However, it was suggested that it is difficult to extract personal information from clients.

Question 19 (C) **What further advice would you give to another province or region considering the adoption of the Prenatal Psychosocial Assessment?**

Summary - With only two respondents little can be conclusively stated, however it appears that role clarification and skilful interviewing that builds a trusting client-provider relationship are important priorities.

Question 20. **Additional comments are welcomed. Please write in the space below or on the back of this page.**

Overall Summary: With n=9 the response rate for the Referral Network was disappointingly low which forbid the formation of conclusions about the PPA. However, the small amount of data collected was positive in nature and suggested that the PPA has potential when the system becomes more familiar with it. Also, the summer implementation period may have reduced knowledge, interest, and response thereby minimizing or under reporting the value of the PPA. Services accessed were typical of prenatal clients so that no surprises were provided by the experience to date in terms of services required in the continuum of care. So far, the continuum of care appears more than adequate. However, if interviewing becomes skillful in identifying and meeting client needs the demand could increase substantially judging from other statistics such as family violence statistics for Prince Edward Island.

Appendix H

Data Summary:
Advisory Committee
Focus Group Discussion

Summary

An Advisory Committee focus group was conducted in late spring of 2000 using a prepared discussion guide and involving a facilitator, two note takers, a Project Coordinator, and nine other Advisory Committee members. The two-hour session was designed to elicit Advisory Committee information regarding the implementation of the enhanced Prenatal Psychosocial Assessment on Prince Edward Island.

Implementation of the Prenatal Psychosocial Assessment (PPA) requires attention to six general categories of prerequisites within the Health and Social Services System: 1) People, 2) Communication, 3) Funding, 4) Procedures, 5) Facilities, and 6) Context. The PPA is a relatively low cost-high return investment if existing system infrastructure and service providers are used to deliver the added service. Specific elements that must be secured and incorporated into the delivery system for the PPA are as follows:

1. Understanding of the PPA model and integrated service delivery;
2. Human resources including champions, right partners, and providers;
3. Physician remuneration;
4. Assessment tools (Client and Physician Versions);
5. Physicians serving prenatal clients and Referral Network
6. Information session resources (guide and video);
7. Referral process;
8. Reports (pilot, interim and final which includes Dissemination Plan);
9. Favorable contextual situation within Health and Social Services system, and
10. Funding to for a new service to the system, inclusive of physician remuneration.

The barriers were managed by the Project Coordinator's ability to a) remain flexible to the specific needs of stakeholders and b) her ability to respect the time and effort to the project by the physicians, Advisory Committee, and Referral Network eg: Public Health Nursing, Community Nutritionist, Community Mental Health, Addiction Services, Outreach Worker, Child and Family services, Victim Services and Income Support.

Facilitators of the PPA Project, or those aspects over which staff have control are:

a) key people identified above
b) confidentiality of the client information
c) full range of services (referral network)
d) existing assessment tools
e) client belief in PPA
f) environmental / cultural support (timeliness of issue) for the PPA
g) program support offered by the Premier's Action Committee on Family Violence Prevention.

The Barriers to the Project, or those aspects over which staff have little or no control are:

a) physician case load or time
b) motivation of the client
c) limited time line rendered by the Health Transition Fund
d) circumstantial events, e.g., inclement weather, holidays, illness, and death.

In total, 13 expected outcomes and 3 unintended outcomes were obtained from the Project (real or potential), and all outcomes were considered to be positive for the pregnant woman, service provider and family. However, the following three were identified as the top 3 by the focus group: a) improved health of Island mothers and their infants, b) more interventions/referrals for psychosocial issues of prenatal women, and c) the level of physician comfort with PPA.

The Focus Group thought that the Project could be transferable depending on the individual project elements and the process used. The champions to the project were a great key, the "sell" with the right partners is crucial and having services in place before implementation is necessary in order to avoid opening a Pandora's box. Transferability of elements "depends" on fidelity to implementation while generalizability of outcomes is "potentially" possible. Overall, the PPA will enhance the quality of prenatal care. Generalizability is directly dependent on the transferability of the project. Only after the PPA is demonstrated to be transferable, can it be determined to be generalizable.

1. What System Prerequisites were needed for the success of the Project?

Category	Pre-requisite
People	▸ The Champions of the project were "key". They included the Project Coordinator, Family Violence Consultant, Physicians and the Steering Committee. ▸ Must have multi disciplinary team of professionals and the "right partners." People required are doctors, public health nurses, project coordinator, Advisory Committee, receptionists, and referral network. ▸ In-kind staff enhanced human resources for project. ▸ Need commitment and support of System decision makers, as well as, client support.
Funding	▸ Having previous funding to conduct a pilot reduced costs at present stage of development of project. ▸ HTF funding to cover project costs, and Medicare coverage for physician fee was essential. ▸ The PPA was not a costly project as referral network staff was funded through Health and Social Services (regular work). Moreover, they didn't have to sacrifice any other work to provide consultation to prenatal clients. i.e., in-kind staff. ▸ In-kind support provided by the existing infrastructure assisted greatly, e.g., board room.
Facilities	▸ No new facilities were required. Existing facilities and services permitted the addition of enhanced psychosocial assessments without new purchases/facilities.

Category	Pre-requisite
Communication	▸ The effort made to inform physicians and service providers was appreciated, e.g., M.D. office information sessions and network talks by the Project Coordinator. ▸ Flexibility in terms of the information session length was required due to restricted provider availability. ▸ Being able to tell stakeholders that the Project received broad support from national groups aided acceptance, e.g., Society of Obstetricians and Gynecologist, College of Family Physicians, as well as the support of the Medical Society of PEI and the Project Advisory Committee. ▸ Written and AV materials and personal communication provided a pleasing communication package to promote project to providers. Mail-outs "would have failed".
Procedures	▸ The amount of detail to project increased acceptance. ▸ Declaring the project to be sustainable and to be aimed at 100% of pregnant women also aided acceptance. ▸ The pre-existing prenatal database assisted the effort. ▸ Positive peer-pressure brought others aboard, i.e., "Everyone saw it as a joint effort". ▸ Being accommodating to the physicians and referral network through on-site visits and using a labor intensive process by the Project Coordinator sent a nonverbal message that increased project acceptance. ▸ Existing clinical procedures were used whenever possible to facilitate implementation of the PPA. For those physicians not routinely offering full term prenatal care, the PPA was adopted for purposes of the Project. conducting prenatal care, it was new to their practice ▸ *NOTE:* Not all physicians in PEI offer prenatal care. ▸ Having physician remuneration is a necessary part of the procedure.

Category	Pre-requisite
Context	▸ Referral services already in existence sped up Project. ▸ Having PEI pilot completed and having University of Toronto developed tools increased acceptance. ▸ It was a timely topic being related to the research and priorities of the Premier's Action Committee on Family Violence Prevention. ▸ Results were something that staff "could do something about" made project attractive and doable. ▸ Having a multidisciplinary Advisory Committee to guide a multidisciplinary service was viewed positively. ▸ Having the "champion" role, support and direction within this committee added to the Projects' credibility. ▸ Past experience in working with physicians and knowing how to approach them improved procedures/outcomes. ▸ Physicians received payment for sustainable services rendered was positive (but the fact that they were not compensated on par with other services was negative). ▸ The beneficiary is the client ("...women were involved... women liked this pilot") also strengthened this project.

2. What are the project elements?

#	Elements	Sub-elements
1	**Model**	Integrated Service Delivery
2	**Human Resources**	The Project champions, Project Coordinator, physicians, Public Health Nurses, Advisory Committee, in-kind staff, receptionists, referral network, System decision-makers, beneficiaries/clients. Focus group participants said that "...Planning, people, cooperation ..." were critical elements.
3	**Remuneration**	Fee Code 2505 Counselling up to 20 minutes $ 19.35 2506 Counselling for over 20 - 45 min. $ 23.20
4	**Assessment Tools**	Ask Me! Identifying Stressors in Pregnant Women (Client)
		Prenatal Psychosocial Health Assessment Form (Physician)
5	**Physician / Referral Network Education Materials**	Small group/1:1 education sessions with agenda and materials customized to individual circumstances to attain good communication: "...the communication piece is most critical".
		Alpha Pilot Report
		Demonstration Video
		PPA Reference Guide
		Prenatal Resource Directory
6	**Referral Process**	Referral/Communication Form
		Referral Network information sessions with agenda and materials that addressed their needs: "Process is a significant element".
		Prenatal Resource Directory

Project Elements - Continued		
7	**Reports**	▸ Existing Pilot report ▸ HTF Reports *(Interim completed and Final to come)* ▸ Other dissemination completed-, *e.g.,* Presentation to Island-wide Health Promotion Conference ▸ Post-project dissemination
8	**Context**	▸ Working in an environment with highly functioning medical professionals who were highly committed and recognized the time to undertake such a project with busy physicians eg:. Project Coordinator, Family Violence Consultant and the Referral Network. ▸ Respect for the way different people work "to make it happen" which included flexibility and excluded 'one size fits all'. ▸ Time was an accelerator for cultivating relationships among professionals and implementing new procedure. ▸ Commitment: "Time and commitment to the project was huge" considering total workloads on the part of the physicians, Project Coordinator and Family Violence Consultant but was balanced with people's outlook and their patience only to go just 'so fast' and no more. They were already stretched, but agreed to extend their service. ▸ Had an Island focus: Province-wide initiative, small province, able to drive the distances, known contacts ▸ Evolutionary in nature as people accepted the fact that it was a 'work in progress' and "...somewhat evolutionary in a way..." ▸ Knowing that a pilot had been completed was positive to some providers to the point where it allowed for funding of the demonstration project.

3. What were the facilitators and barriers of the Project?

1. Facilitators?

- Having a deadline to meet or work towards.
- Conducting a pilot phase and having the report already available
- Practitioners able to link with the Referral Network and individual service providers.
- Having champions to the project: Project coordinator, Family Violence Consultant, Physicians, Steering Committee
- Physician keeping client information confidential and in the patient's file.
- Physician trust of the project goals and claims.
- Having full range of services
- The small size of PEI was an advantage for travel, communication, meeting goals, etc.
- Uncomplicated access to French language translators
- Women's participation in their personal decision-making helped to make women feel more "in-charge" and therefore to participate and support the PPA
- Tools available to assess prenatal women were evidenced-based
- The project addressed a timely issue when family violence was a timely topic
- Significance of Project; it could make a difference in the lives of women and children".

2. Barriers?

- Having to work province-wide was a challenge at times.
- Physicians unaware of the urgency in regards to the limited time frame for the project (unlike the researchers who said:) "We didn't determine the time-frames. They were determined for us".
- Physician attitude of "one more thing to do in an already busy schedule"
- Difficulty in coordinator accessing physicians
- Service areas already 'maxed-out" so difficult to take more clients
- Having no control over the motivation of the client
- There were other barriers that were termed "Circumstantial Barriers", i.e., Project Team had no control over poor weather for travelling, occurrence of Christmas season during project, physician death in an under served community, and an unexpected influx of patients to physicians during the winter flu season.

3. How were the barriers managed?

- The Project coordinator remained as flexible as possible in meeting the needs of the providers whether physician or referral network, e.g., planning of training sessions.
- There was limited space for managing the barriers, i.e., the size of practice and size of caseloads demanded that the physician make the clients the Number One priority
- Respect and pay for the pressure placed on all participants: Project coordinator, Family Violence Consultant, Physicians, Steering Committee and the Referral Network . "The time and commitment to the project was huge".
- Remuneration for the physicians
- Remuneration was provided, but in different ways, to the physician who is self-employed and to those employed by the system.
- Willingness to fit new services in already tight schedules

4. How might these barriers have been avoided?

- Physicians received payment for sustainable services rendered but were not compensated on par with other services, an issue that should be addressed further by system and physicians..
- Additional medical staff in the province would reduce the size and work-load of practices so projects such as this one would be more manageable.
- Implement the Project on a regional or local rather than provincial level to keep it manageable
- More lead-time for Project planning and evaluation between the time of its approval and to completion
- Concern that one might open a Pandora's box by identifying something you can't do anything about was addressed by ensuring that all required services were in place before starting project.
- Concern that referrals would not be followed-up was addressed by putting referral network and referral process in place ("...making the referral and not hearing back...you are out of the loop").

4. What were the expected outcomes / achievements from the Project?	
#	Expected outcomes / achievements from PPA
1	Raise Physicians awareness of PPA
2	Physicians are more comfortable with PPA.
3	Physicians are more committed to PPA.
4	Physicians are more skilled in performing PPA.
5	Physicians are completing PPA with all pregnant women.
6	Prenatal records are more complete.
7	Referral networks have been established in each health region.
8	More interventions/referrals made for psychosocial issues of pregnant women.
9	More collaboration within the prenatal care delivery system.
10	No omission of services within the prenatal care delivery system. "Filling in a 'gap' that previously had been missed.
11	More timely response to the psychosocial needs of pregnant women.
12	Improved quality of intervention/service for pregnant women.
13	Improved health of Island mothers and their infants.
14	Increase client comfort in discussing these issues.
15	Satisfaction from 'doing good' for the client and society.
16	Generalization of tool to other clients.

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15	Satisfaction from "doing good" for the client and society.
16	Generalization of tool to other clients.

X/4

Conclusion: All of the above were expected outcomes of the Project with 1-13 being accepted by focus group participants as suggested by the researchers. Items 14-16 in the shaded area were added by the focus group participants as unexpected outcomes that had resulted (or would potentially result) from the Project. All outcomes, expected and unexpected, were considered to be positive for 1) the pregnant woman, 2) the service providers, and 3) the families.

4a. Were all of these items intentional outcomes or achievements? Yes/No?

Yes. All of the outcomes listed in Table 4 (above) were identified as intentional or expected outcomes. The Focus Group identified the following the Top 3 outcomes as having special importance (#13, #2 and #8):

#13 Improved health of Island mothers and their infants.

2 Physicians are more comfortable with Prenatal psychosocial Assessment, and

8 More interventions/referrals made for psychosocial issues of pregnant women as expressed in the phrase *"...more case finding when you start asking..."*

4b. Were there other intentional outcomes or achievements?

No.

4c. Were there any unintentional / unexpected outcomes or achievements?

Yes. Items # 14 (Increase client comfort in discussing these issues), Item # 15 (Satisfaction from 'doing good' for the client and society), and Item #16 (Generalization of the assessment to other client populations) were added to the Outcomes list in Table 4. The unintentional outcomes were viewed positively for the pregnant woman, family, service provider, and potentially other populations.

5. *Are the elements of this project transferable to other regions and provinces?*

The response was "it depends". All of the six general categories of elements which were identified in Question #2 are potentially transferable (the Model, Human resources, Remuneration, Assessment tools, Physician/Referral network/Education materials, Referral process, Reports, and the Context). Whether they are actually transferrable depends on the configuration of the same six elements in the recipient region or province. With favourable circumstances the PEI program elements could be transferrable.

5.1 Are the other regions or provinces the same as the PEI situation in terms of psychosocial assessment of pregnant women?

Jurisdictions deciding whether to transfer the PEI PPA to their area would have to examine their own area carefully in comparison to the PEI experience to determine if all of the elements are transferable to their setting. Focus group participants stated that the PEI Package should be adopted as a total package (rather than adopting only certain pieces of the package) as it is the basic package that is required to do the job. The considerations include the following:

- Service delivery set up (including existence of providers or provider network)
- Cultural background of the client
- Physician remuneration
- Referral process (establish a Referral Network before project training commences)
- Geographic size / travel scope
- Permission from Alpha Team to use/alter assessment tools
- Existence of midwives
- Process of getting information to and cooperation of physicians
- Ratio of Obstetricians to Family Physicians
- Amount of overall and dedicated human resources ("If you didn't have one person designated, it wouldn't happen" showing the importance of a Project Coordinator)

Would the project work the same in those regions or provinces?

The focus group respondents agreed: 'It depends.' As noted above, it would depend on the mix of circumstances in the new jurisdiction as compared to PEI.

5.2 What elements of this project are particularly transferrable to / usable by other regions or provinces?

There were no single elements that were specified. It is expected that the Prenatal psychosocial Assessment must be transferable as an entire package. This is because it is considered to be 'bare-boned', with all elements being critical and basic to the Project.

Key issues in getting this project up and running in other settings were identified as:

- The notion of champions is said to be the determining factor in the Project's success
- The ability to 'sell' the Project to various players and gain agreement to participate
- Remuneration for physician or salaried physician eg: current pilot in Souris.

Overall, all elements are potentially transferable, though possibly in a modified form. These elements include: the Model; Human resources; Remuneration; Assessment Tools; Physician/Referral Network, Education Materials; Referral Process, Reports and the Context. These elements may look different in PEI because of our small size, ability to travel the province, knowing contacts and service delivery system.

5.3 What resources were created that could be used to transfer the model or learnings to other regions or provinces?

- Highly trained resource people who care and can deliver Project information to their professions or at conferences and meetings (Project Coordinator, Family Violence Consultant and Reproductive Care Coordinator)

- The willingness to participate in a socially worthwhile project
- Required services (if a particular service was not available that is required in the area for the type of referrals made then it would be necessary to identify its available equivalent before deciding whether it is necessary to establish a new service)
- The existence of the prenatal assessment service itself
- The Prenatal psychosocial Health Assessment Reference Guide Book
- The enhanced / PEI friendly version of the PPA tool and Reference Guide
- Demonstration video and Prenatal Resource Directory
- Referral Communication Form
- Physician remuneration
- Champions, specifically, the PPA Project Coordinator and the Family Violence Consultant who championed the project in their respective jurisdictions of influence and were "the key to the Project's success"
- PEI service including the service provider experts, the service delivery infrastructure, and the established assessment, referral and intervention procedures. That is, the PPA Coordinator and the Family Violence Consultant created a service delivery system based on the integrated care model which gradually became institutionalized. By visiting PEI or viewing a training video of the PEI experience, decision-makers from other jurisdictions can access and benefit from the PEI experience when considering PPA.

5.4 Who are the potential users of this information?

The focus group participants suggested the following potential users:

- Health Canada including the Health Transition Fund
- Advocacy organizations, e.g., Status of Women
- Community organizations, e.g., CHANCES, Transition House
- Referral Network
- National professional organizations, e.g., College of Family Physicians
- *All* physicians
- *All* clients

5.5 *What further recommendations or advice would you have with regard to the transferability of this project?*

Other recommendations of the Advisory Committee focus group regarding transferability were:

- Plan Ahead - "Think before you leap", or give considerable thought and planning before transferring the model to the new setting.
- Right Partners - Establish a broad support group composed of the "right partners" from the outset. This is inclusive of project champions: Coordinator, Advisory Group, MD's.
- Referral Network /Equivalents - If the Referral Network is not established, be sure to identify or establish equivalent supports / services before prenatal clients are diagnosed.
- Adapt Tool to Local Needs - Investigate adaptations of the PPA tool with the originators giving consideration to a) original ALPHA tool, PEI Tool, and their regional / provincial requirements.
- Training - Use learning packages as developed on PEI with only minor adaptation for geographic and service differences. Consider the number of trainers required in relation to the size of the recipient jurisdiction and the methods used to reach physicians and referral network providers for training.
- Interviewing Skills - Investigate and learn from the PEI physician experience in developing skills or techniques for asking questions.
- Physician Reimbursement - Negotiate the physician remuneration at the outset.
- Service Delivery Model - Consider differences in service delivery, e.g., the percent of obstetricians doing prenatal care and the availability of midwives.
- Staffing Levels - Consider the size of the province, and planned method of implementation.
- Referral Patterns - When deciding referral possibilities consider travel distance and method of service delivery so that it is practical for clients.

- Language - Consider the language and translation needs of the target population.
- Culture - Consider the cultural adaptations required for the target population.
- Develop Guidebook - Develop a guidebook that encompasses all relevant applied experience to date, including the PEI experience with the PPA.
- Review PEI Resources - View the proposed "Island Focus" videotape, papers from conferences, and any other resources that depict the PPA.
- Site Visit - Visit PEI to gain first hand experience with the PPA philosophy, structure, and processes to get a better match between PEI and target site.

6. Are the outcomes or achievements generalizable?	
#	*OUTCOMES OR ACHIEVEMENTS*
1	***Physicians have more knowledge/ awareness of PA.***
2	***Physicians are more comfortable with PA.***
3	***Physicians are more committed to PA.***
4	***Physicians are more skilled in performing PA.***
5	***Physicians are completing PA with all pregnant women.***
6	***Prenatal records are more complete.***
7	***Referral networks have been established in each health region.***
8	***More interventions/referrals made for psychosocial issues.***
9	***More collaboration within the prenatal care delivery system.***
10	***Less duplication of services within prenatal care system.***
11	***More timely response to the psychosocial needs of women.***
12	***Improved quality of intervention/service for pregnant women.***
13	***Improved health of island mothers and their infants.***

Yes. The outcomes are likely to be generalizable to the extent that the elements of the intervention were transferable and were implemented in accordance with the PEI protocol. If the setting allows this type of service, i.e., if the project is transferrable, then the results seen here on PEI are potentially generalizable. As one focus group participant noted, by introducing universal PPA "We're changing the standard of prenatal care in the province."

Appendix I

Eight Dissemination Methods for ALPHA Pilot

Eight Dissemination Methods for ALPHA Project

1. Information packages were distributed to professional workers, and relevant groups and organizations. A total of 250 packages each containing The ALPHA (Antenatal Psychosocial Health Assessment) Pilot Study Report were disseminated across Canada to professional workers including family physicians, obstetricians, pediatricians, Public Health nurses, nutritionists, Child Welfare supervisors, Community Mental Health managers, Addiction Services, Outreach Workers, and Victim Services workers. Groups or organizations receiving the report or information packages were the Project Advisory Committee, the Premier's Action Committee on Family Violence Prevention on PEI and provincial Family Violence Coordinators, Canadian Perinatal Programs Coalition members, and ALPHA Team from University of Toronto, etc.

2. Oral presentations, 70 of them, were made across PEI to health region staff, provincial and hospital perinatal committees, Public Health Nursing, referral network personnel, and the Premier's Action Committee on Family Violence Prevention. Of the 70 presentations 47 were part of an education session provided to physicians. Project staff requested to be on meeting agendas.

3. Poster presentation was presented at The Medical Society of PEI's Annual Meeting

4. An abstract has been accepted for presentation at the North American Primary Care Research Conference to be held in November of 2000 in cooperation with the ALPHA Team at the University of Toronto.

5. Journal articles were submitted to the Canadian Family Physician Journal and the Canadian Journal of Nursing Research.

6. Media releases were issued but only when project was announced by Health Canada given the sensitive nature of the project.

7. Newsletter of the Medical Society of PEI printed information for members.

8. Education sessions were done by the PPA Project Coordinator.

Appendix J

Guidelines for Education of Physicians

Guidelines for Education of Physicians

1. Sent an invitation in advance to prepare them for the session;
2. Met at the physician's office or nearby location over meal and provided food to save physician time;
3. Kept the session length to 1-1.5 hours for small groups (or one-to-one presentation in doctor's office usually 20 minutes in length);
4. Ensured that the physicians received continuing education credit for the training session (although it was not an important consideration for most physicians);
5. Employed flexible scheduling of time, location, and group size (1:1);
6. Included information about the pilot results, project rationale, project model, and progress to date;
7. Employed flexible scheduling of time, location, and group size (1:1);
8. Provided resource package to facilitate use;
9. Explained the PPA forms and how to complete them;
10. Described the Referral Network Directory and referral procedure to establish collaboration;
11. Demonstrated the assessment through the use of a video to promote acceptance;
12. Explained billing codes or compensation for performing the assessment;
13. Asked a local, well-respected physician role model to accompany the training team when available / volunteered;
14. Provided contact information for the Project Co-ordinator so that she could be readily contacted, if necessary.

Appendix K

Education Resource Package

Education Resource Package

Educational Materials Used and Resources Provided

1. **Demonstration Video (physician-mother interview shown at session)**
2. **Prenatal Resource Directory(inventory of resources)**
3. **Prenatal Psychosocial Health Assessment Forms(actual forms)**
3. **Referral/Communication Form (Physician complete)**
4. **Prenatal Psychosocial Assessment Reference Guide**

Resource Directory - The Resource Directory listed services available, contact numbers and addresses for each health region, where applicable. The eleven services were:

1. **Addiction Services**
2. **Child and Family Services/Income Support**
3. **Community Mental Health**
4. **Community Nutrition**
5. **Family Resource Centres/CHC**
6. **Family Violence Services**
7. **Marital & Family Counselling**
8. **Parenting Courses**
9. **Parenting Courses**
10. **Teen Parents School-Based Support Groups**

Prenatal Psychosocial Health Assessment Reference Guide - The Prenatal Psychosocial Health Assessment: Reference Guide was used to explain the Prenatal Psychosocial Assessment (PPA) and provide trainees with a ready reference for use when working independently in their offices. The content of the reference guide included:

1. **History of the ALPHA group**
2. **History of the Prenatal Psychosocial Health Assessment**
3. **The Reference Guide for Providers**
    - i. **Design of the form**
    - ii. **Set up of the Guide (Factors- evidence of association; facilitating disclosure / how to ask / interventions /what to do)**
    - iii. **Selected Bibliography**

Appendix L

Media Coverage

Federal funding promotes integration in health-care services

Four Island projects will receive $550,000 from Ottawa

BY RON RYDER
Guardian Weekend

Four Island health projects will be getting $550,000 in federal funding under a program designed to promote integration in health-care services.

At a Friday evening press conference, Health and Social Services Minister Mildred Dover and Solicitor General Lawrence MacAulay announced latest local initiatives to be funded and evaluated under the Health Transition Fund.

The Health Transition Fund was established in 1997 with the intent of generating information on the organization, funding and delivery of health services in the areas of home care, pharmacare, primary care and integrated service delivery.

Projects are being carried out in all provinces and territories and information will be shared nationally.

MacAulay said finding ways of integrating the system will allow for more effective client-focused delivery of health care.

"This integration approach places the needs of people ahead of the needs of the system," he said.

"We have an opportunity to help shape the future of health care not just on P.E.I. but right across Canada."

Dover said the four projects selected for funding are aimed at particular needs but would help improve the health system for Islanders in general.

"The projects we are undertaking are excellent examples of areas in which our system is changing to better meet the needs of Islanders," she said.

The four projects earmarked for support include an integrated mental-health response for seniors, enhancement of prenatal assessment and care, integration of services for autistic children and a provincial support program for teen parents.

The prenatal assessment program will look at the health and social condition of expectant mothers prior to their giving birth. It will particularly look for psychosocial risk factors such a stress, abuse, social support or addictions that can have a bearing on the outcome of a pregnancy.

The seniors' mental health project will focus on integrating home care and mental health services for seniors suffering from dementia, depression or both. The aim is to streamline the identification, diagnosis and management of mental health problems among seniors.

The autism integration project is aimed at improving services for children with autism across the province. The goals include reducing dependence on out-of-province experts, reducing the need for long-term intervention and services, and reducing stress in families with autistic children.

P.E.I. HEALTH MINISTER Mildred Dover speaks with Dr. Ron Siemens and federal Solicitor General Lawrence MacAulay during a press conference Friday in Charlottetown. Siemens is leading an autism integration project, one of four projects on P.E.I. to receive joint federal and provincial money. All four projects are looking at ways of integrating health-care services.

Guardian photo by Nigel Armstron

The teen parent support program will work with high school students, building on existing programs. It will involve using a multidisciplinary approach to help teen parents acquire the knowledge and skills necessary for their health and that of their child.

Dover said the new projects will be funded for two years to assess their benefit and the results will be used to determine future policy.

She said the aim is part of the health system's constant effort to maximize the benefit it gets from limited dollars.

"We're looking at new ways, innovative ways to deliver services," she said.

APPENDIX I

Volume III Issue 6
July/Aug. 1999

The Pulse

PRESIDENT'S LETTER:

Dear Colleagues:

I hope the summer has been enjoyable and restful for all of you. It really has been a gorgeous PEI Summer.

To start with, I would like to thank all physicians and other participants who took part in the political skills workshop which was held on June 13 following our Annual Meeting in Mill River.
Also I would like to thank the CMA for all its help and support as well as the kind participation of Mr. Wayne Easter, MP, Ms. Beth MacKenzie, MLA, and Dr. Herb Dickieson, MLA for their guidance, help and understanding of the importance of an ongoing political dialogue to resolve vital issues facing medical practice and health care strategy in general. I would also like to thank Dr. Harry Callaghan for his skilful chairing abilities during the workshop.

Regarding PhIP legislation, the Government has decided to drop the linkages until such time when there is a Health Information Act to protect our patient's confidentiality as well as the general publics interest in this area.

The Medical Society's Board, at their last meeting , also endorsed the Prenatal Psychosocial Assessment Project to be carried out by the PEI Reproductive Care Program. This project is based on the results of the two year ALPHA pilot study in which four family physicians participated. Physicians will be asked to complete their assessment on all pregnant women. Education sessions will be organized by the program in the fall to familiarize physicians with the assessment process. Drs. Rob Kelly, Pam Forsythe, Pam Sproule and Kathy Bigsby are members of the Project Advisory Committee and ask for your support.

I would also like to mention two issues which I believe should occupy our thoughts and planning during the next year.

The first issue is the Master Agreement. We have a good agreement but it was a learning experience for us and within the next year or so we should start preparing ourselves for the next round of negotiations. We should start making a list of priorities so that we will be ready this time to start negotiating with the Government in a concrete, definitive, and knowledgeable manner.

There are a lot of things left out or not complete in our present Master Agreement and we should make every effort to ensure that they are amended to properly in the next Agreement.

The second issue is related to a steady decline in the number of physicians gradusting and also the massive retirement of the baby boomers within the next 5-10 years.

We must develop, as soon as possible, a long term strategy preferably partnering with Government and our community to ensure that physician manpower requirements are met if we are to maintain the present level of health care services

In the long run it will not be a money issue only. It will be an issue of availability as physicians patterns of work are changing. Family life and life style in general are as important as career issues.

The shortage of psychiatrists and anesthetists on PEI is only the tip of the iceberg. We must start working now towards a strategic plan to meet this challenge. If we don't act now, physicians shortage in the near future will have a devastating effect on health care services in this province.

(con't on page 2)

Inside this issue....

Board Highlights 2
Items of Interest 2
Claims Corner 3
Student's Corner 3
MD Management News 4
Upcoming Meetings 4
CMA News 5
Upcoming Meetings (Con't) 6
The Look of Unhealthy Lungs 7
Life Membership Award 8
Senior Members Award 8
TrailFest 9
Drugs & Therapeutics ..... Insert
Dalhousie Medical Journal ..... Insert
Joint Statement: Reducing the risk of Sudden Infant Death Syndrome ..... Insert

Newsletter of the Medical Society of Prince Edward Island *http://www.mspei.org*

AUG 31 '99 10:32AM MEDICAL SOCIETY PEI P.2